THE FEDERAL EMPLOYEE HEALTH BENEFITS PROGRAM

HEARING

BEFORE THE

SUBCOMMITTEE ON COMPENSATION AND EMPLOYEE BENEFITS

OF THE

COMMITTEE ON POST OFFICE AND CIVIL SERVICE HOUSE OF REPRESENTATIVES

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THE FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM

WEDNESDAY, MAY 24, 1989

HOUSE OF REPRESENTATIVES,
COMMITTEE ON POST OFFICE AND CIVIL SERVICE,
SUBCOMMITTEE ON COMPENSATION AND EMPLOYEE BENEFITS,
Washington, DC.

The subcommittee met, pursuant to call, at 11:34 a.m., in room 311, Cannon House Office Building, Hon. Gary L. Ackerman (chairman of the subcommittee) presiding.

Mr. ACKERMAN. The subcommittee will come to order.

Today the Subcommittee on Compensation and Employee Benefits will continue its oversight hearings on the Federal Employees Health Benefits Program. This hearing will focus on the FEHBP study prepared by the Congressional Research Service, as well as the status of the General Accounting Office review of the program.

The FEHBP is an $11 billion health insurance program which covers approximately 9 million Federal workers, retirees and their dependents.

Over the past decade, the FEHBP has strayed from the principle of group insurance and is no longer meeting its goal of providing comprehensive and affordable medical insurance to all its enrollees. Adverse selection and escalating premiums plague many of the health plans, and "open season" choices are confusing to even the most well-informed health care consumer. The program does not adequately serve its enrollees and it is in danger of collapse. The Congress will not sit idly by as Federal workers and retirees are forced to pay the costs of an inefficient, inadequate and confusing health insurance program.

Last year, Chairman Ford and I requested that the CRS perform a comprehensive analysis of the FEHBP. This request followed two days of oversight hearings on the program. At that time, I believed that the FEHBP was in need of fundamental reform. Nothing has happened within the past year to alter my belief. The CRS report reflects the combined efforts of the Congressional Research Service, the Congressional Budget Office, and the General Accounting Office. It identifies the major weaknesses of the FEHBP and provides an objective framework from which this subcommittee can begin to design a comprehensive health plan for current and future Federal enrollees. The subcommittee plans to develop substantive and bipartisan FEHBP legislation later this year.

The Chair is delighted to be welcomed here by Congresswoman Morella, inasmuch as you preceded my appearance, which I do

apologize for being late. I was trying to avoid having to adjourn this temporarily for two very important votes in the Foreign Affairs Committee that I will have to make. I thought I would be able to do that before coming over, but that didn't happen, so we lost on both ends.

Lynn Morella.

Mrs. MORELLA. Thank you.

Mr. Chairman, we are glad you're here. We have been waiting with great anticipation for this hearing. As a matter of fact, I also do want to commend you for arranging for the hearing in such a prompt fashion so early in the session.

In regard to constituent interest on the issues before this subcommittee, I must say that the Federal Employee Health Benefits Program ranks second only behind the pay raise—or maybe I should say behind also catastrophic health insurance. I received innumerable calls inquiring about when there will be a hearing, when the reports will be available, and, most frequently, when will there be legislation to improve the present FEHBP; and also, when will there be a program to give the Federal employees and their families a comprehensive program which reflects the vast sums that the participants and the Government contribute.

The cost of health insurance has skyrocketed, and a pay raise or COLA is dissipated by the increase in premiums for health benefits. The Government contribution alone has increased $3.3 billion within the past three years. Double-digit inflation, decreased plan benefits, increasing risk segmentation and administrative costs all further signal the urgent need for Congress to take a hard look at the present program as it is structured. Indeed, Mr. Chairman, with these concerns in mind, we should be able to develop a comprehensive program, and I know this is the beginning.

Health care is essential. We cannot afford, either as individuals, families, or as a nation, to have inadequate coverage. Medical bills can often wipe out families. We cannot offer Federal employees and retirees plans which do not represent the very best that can be negotiated.

Mr. Chairman, I certainly will work with you to develop legislation to overhaul the FEHBP in an effort to better address the needs of today's family and society. Substantial changes have taken place within the past 30 years in our Nation which affect our health care needs. Our life expectancy is longer, new diseases have been identified. Many of them do not have cures but need expert treatment and new expensive medications. Testing has become standard practice for an accurate diagnosis, and perhaps partially because of our litigious society. These factors all play an important role in the cost of health insurance.

However, because the Federal Government is a large contractor, we must ensure that our dollars and negotiations go a long way toward providing the best benefits for Federal employees and retirees. Towers, Perrin, Forster and Crosby, commissioned by the Office of Personnel Management, have completed a comprehensive study which identified major pitfalls of the FEHBP. The Congressional Research Service document, I am sure, will be as useful in our effort to reform the FEHBP. And as you are aware, Mr. Chairman, the CRS report has been unavailable for comprehensive

review until a very late date. I will not be able to comment on its contents until I hear from the witnesses today. Perhaps we'll have further questions on that.

I hope that that report and this subcommittee will address the issue also of duplicative catastrophic health coverage for our Federal retirees. This has been one of the major concerns of the session, and it's one that I think we cannot avoid addressing.

Again, Mr. Chairman, I look forward to working with you and all those concerned in making the FEHBP an ideal benefit for employees. I thank you, Mr. Chairman.

Mr. ACKERMAN. Thank you, Mrs. Morella, for your expertise, your willingness and your cooperation. I look forward to working with you in making this a truly bipartisan piece of legislation. It is something that politics should and shall play no part in. I think both the majority and the minority will put this thing together, and hopefully it will be something of which we all can be very proud.

Our first witness today will be Jerome Julius, Deputy Associate Director, Retirement and Insurance Group, of the Office of Personnel Management.

STATEMENT OF JEROME D. JULIUS, DEPUTY ASSOCIATE DIRECTOR FOR RETIREMENT AND INSURANCE, OFFICE OF PERSONNEL MANAGEMENT; ACCOMPANIED BY REGINALD M. JONES, JR., ASSISTANT DIRECTOR FOR RETIREMENT AND INSURANCE POLICY, AND NANCY KICHAK, DIRECTOR, OFFICE OF ACTUARIES

Mr. JULIUS. Good morning, Mr. Chairman.

Mr. ACKERMAN. Good morning, Mr. Julius. Welcome. Please introduce those who accompany you on the panel.

Mr. JULIUS. I would be glad to, Mr. Chairman.

I am Jerome Julius. I guess that's obvious by now. To my right is Mr. Reginald Jones, who is the Assistant Director for Retirement and Insurance Policy, and to my left is Mrs. Nancy Kichak, who is Director of the Office of Actuaries.

Mr. Chairman, we thank you for the opportunity to discuss the current status of the Federal Employees Health Benefits Program.

In May of last year, the Director of OPM appeared before this same subcommittee to report on the Towers, Perrin, Forster and Crosby study of the FEHBP. That study concluded that the FEHBP is in serious need of reform to restore equity and to promote efficiency.

Since that hearing, OPM has been actively engaged in an effort to elicit the views of all interested parties, with an eye toward developing a reform proposal that will draw broad-based support.

First, the TPF&C report was widely disseminated to interested parties inside and outside of Government. In July, OPM conducted a public hearing on the FEHBP program. Among the participants were a number of FEHBP insurers and employee organizations.

In September, OPM sponsored a symposium on State and local government health programs for public employees. Representatives from selected public jurisdictions shared their experience and ideas

in the areas of program design and administration with OPM and congressional staff.

In October, OPM cosponsored, with the National Academy of Public Administration, a public conference on reforming the FEHBP. A distinguished panel of outside experts was assembled to speak on some of the key reform issues. The 200-plus conference participants represented a wide array of interested parties—for example, FEHBP carriers, agency personnel directors, congressional staff, Federal employee organizations, health industry interest groups, research institutes, and benefits consulting firms.

Over the last year, OPM staff have conducted over 50 briefings on FEHBP reform, primarily for Federal managers and employee groups throughout the country. We are presently working with a contractor on an opinion survey to be conducted this summer among a random sample of Federal employees and annuitants to ascertain their views on the FEHBP and possible program reform.

We believe that the insight that OPM has gained through these various activities will prove most useful as we proceed to formulate a specific reform proposal. While we have found that there are many different views as to what constitutes an ideal employee health benefits program, at least we have a better understanding of the problems facing the FEHBP and of the various alternatives for addressing those problems.

The FEHBP is in dire need of comprehensive reform. Pending development and agreement on a far-reaching reform, President Bush's 1990 budget plan contained an interim financing proposal for the FEHBP which would change the Government's contribution to reflect more accurately the current distribution of enrollees among the health plans.

Under current law, the Government contribution to the FEHBP is based on the unweighted average premium of the six health plans. The proposal in the 1990 budget would help to correct the inequities generated by the current formula by revising it to use the weighted average premium of all health plans.

We are anxious to begin in earnest the process of formulating a specific reform proposal on behalf of the administration. While we have not had time to fully review the report prepared by the Congressional Research Service, we are sure that it will prove to be a valuable resource. We look forward to working with the Legislative branch staff as the reform effort moves along.

Mr. Chairman, that ends my statement. We will be ready to answer any questions.

Mr. ACKERMAN. Thank you very much, Mr. Julius.

As you are aware, of course, today's hearing has as its focus the new report by CRS. It is my understanding that the CRS had asked your agency to review and make comments on a draft of this report.

Based on OPM's review, could you comment on the findings of the CRS report?

Mr. JULIUS. Mr. Chairman, I am not aware of being asked by the CRS to review a draft of this report. I received a copy of the final report Monday afternoon. I was asked to review the report by myself. I had time to read the overview of the report, and I will be

glad to comment on that. Other than that, I have no basis for making any other comments on the report.

Mr. ACKERMAN. Had anybody else in your organization been asked to review——

Mr. JULIUS. Not that I'm aware, Mr. Chairman.

Mr. ACKERMAN. One of the major findings of the CRS report is that the value of FEHBP benefits' lag significantly behind the value of health benefits available in the private sector. Does OPM support the goal of comparability with non-Federal health plans?

Mr. JULIUS. That certainly should be one of the criteria we look at in reviewing whether or not we believe the program is adequate for our employees.

It is a difficult question to answer, mainly because compensation policy includes more than just health benefits. We need to look at the whole compensation package. I believe that we have in the past talked about total comparability and have not yet found a way to accomplish that.

Mr. ACKERMAN. Last year the Congress passed legislation to authorize OPM to exclude fraudulent health care providers, but that new law has not been implemented. Two days ago I finally received a response from OPM explaining the reason why the regulations have not been issued. The letter states that OMB wants to create what they call "common rules" for Government-wide suspension and debarment. The new law seems very clear in terms of the implementation of debarment and the procedures and imposition of civil sanctions, so it should not, in my opinion, require extensive implementing regulations.

My question is, under what authority may OMB, in effect, veto the legislation? And if the delay goes on much longer, will OPM act unilaterally to implement the new law?

Mr. JULIUS. Mr. Chairman, we have to clear all regulatory packages through the Office of Management and Budget. OMB believes that, in their opinion—at least one staff member's opinion—no new regulations are needed in this area. We have asked our General Counsel to advise us on this matter. So we hope to resolve the matter soon.

Mr. ACKERMAN. It wouldn't take another year, would it?

Mr. JULIUS. I hope not, Mr. Chairman.

Mr. ACKERMAN. If there is no objection, I would like to insert the letter from OPM into the official record at this point.

[The letter follows:]

UNITED STATES
OFFICE OF PERSONNEL MANAGEMENT
WASHINGTON, D.C. 20415

Office of the Director

MAY 22 1989

Honorable Gary L. Ackerman
Chairman, Subcommittee on Compensation
and Employee Benefits
Committee on Post Office and Civil Service
U.S. House of Representatives
Washington, D.C. 20515

Dear Mr. Ackerman:

This is in response to your recent inquiry concerning the regulations necessary to implement title I of Public Law 100-654 which provides for the exclusion of health care providers who have been convicted of certain types of criminal activity from participating in the Federal Employees Health Benefits Program.

Public Law 100-654 was enacted on November 14, 1988. The Office of Personnel Management (OPM) drafted the interim regulations we thought were necessary to implement title I and forwarded them to the Office of Management and Budget (OMB) on December 23, 1988. My staff has met with representatives of OMB as recently as May 1 on our proposed regulations. OMB has indicated that, rather than promulgating a separate body of regulations within the 5 C.F.R. to address the debarment process specifically outlined in Public Law 100-654, OPM should become a signatory agency to the common rules/regulations on Government-wide non-procurement suspension and debarment as envisioned in Executive Order 12549.

President Reagan signed Executive Order 12549, Debarment and Suspension, on February 18, 1986 to ensure consistency among agency regulations concerning debarments and suspensions of participants in non-procurement Federal programs. The Director of OMB was authorized to issue guidelines that would govern which programs and activities would be covered by this Order, prescribe Government-wide criteria, minimum due process procedures, etc. OMB prepared such guidelines in a regulation format. Section 3 of the Order authorized departments and agencies in the Executive Branch to issue regulations governing their implementation of the Order which would be consistent with the OMB guidelines. Thus far, 33 agencies have essentially re-printed the OMB "common-rule" guidelines/regulations as their own. Again, however,

these guidelines/regulations are for non-procurement activities. This has given us reason for concern since the FEHB Program is essentially a procurement - oriented program.

We are currently working with OMB to reach a resolution on the production of debarment regulations which will satisfy the mutual concerns of both parties involved. I hope to be able to notify you within a reasonable timeframe that we have been able to accomplish this.

Sincerely,

James M. Strock
Acting Director

Mr. ACKERMAN. Your most recent call letter to carriers recommends that all FEHBP plans provide coverage for prescription drugs. You propose a $600 deductible, coinsurance of 50 percent, and a minimum lifetime cap of $20,000. I would like to know what was the origin of the suggestion, and does it mean that OPM will be proposing other minimum benefits?

Additionally, why is it you propose a lifetime limit? It's quite evident that drugs for some therapies, such as for the treatment of AIDS and the prevention of transplant rejection, can easily cost more than $10,000 a year. What do those people do after year two?

Mrs. KICHAK. We requested that all plans propose to us the cost of providing that minimum coverage. We did that because several major plans in our program right now do not cover drugs. We felt that this level of drugs would be a substantial improvement in those plans that don't include drugs, that it would be a first start with our current budgetary constraint, to start them at a lower level of benefits.

Mr. ACKERMAN. Why would there be a lifetime limit, considering the cost of these things?

Mrs. KICHAK. We wanted to suggest to a plan that doesn't have any drugs right now, that if they handle the claims for a person who has a severe prescription drug need, that with a lifetime max they could expect that person to select another plan in a future year. At least this would be a minimum level of coverage for them, rather than having nothing.

Mr. ACKERMAN. So basically what you're suggesting then is, after a person uses up—who is in an unfortunate position to be facing these huge bills, in addition to huge health problems—that they deplete their present plan of $20,000 and then go plan hopping for another $20,000?

Mrs. KICHAK. Well, right now they don't have any coverage at all.

Mr. ACKERMAN. That would be their choice, just go from one plan to another?

Mrs. KICHAK. Right now they have to change plans to get any coverage.

Mr. ACKERMAN. OPM's medigap report was supposed to be delivered to Congress by April 1. We didn't receive it until last week. I realize the delay was caused by the Office of Management and Budget, not OPM.

What changes, if any, did OMB make in your report?

Mr. JULIUS. What changes did OPM make in the report?

Mr. ACKERMAN. No, what changes did OMB make.

Mr. JULIUS. There were some minor word changes. Other than that, to my knowledge, there were no major changes made in the report. The report is substantively as it was submitted to them originally.

Mr. ACKERMAN. Basically no changes.

Mr. JULIUS. Right.

Mr. ACKERMAN. OPM's medigap report outlines three different strategies for providing Federal annuitants health care insurance which would better serve them. If FEHBP was radically changed by placing all employees in the same risk pool, which of the three strategies do you think would be the most appropriate?

Mr. JULIUS. That's a toughie. There is at least some question as to whether or not they should all be in the same risk pool. I realize that's your assumption. The strategies vary. The first strategy assumes that medigap would be provided to only those over 65 annuitants who have both Part A and Part B. Everybody else would remain in the same risk pool.

The second scenario suggests that the Government buy Part B for those annuitants over 65 who only have Part A. The third scenario would provide the buying in of medicare for all of those over 65 who do not have the medicare.

If you were to put all of those folks in the same risk pool, it isn't clear to me which one of those you would want to do.

Mr. ACKERMAN. In terms of the buy in, I understand that this option would cost approximately $669 million. With $1.2 billion in the FEHBP reserve fund, would it be feasible to use this reserve to buy nonmedicare eligibles into medicare?

Mrs. KICHAK. The current balance in the contingency reserve that you refer to is obligated under regulation for payment under regulatory formula to the health carriers, so a large portion of that fund is going to be paid over to them this year to pay claims and administrative expenses.

The over $600 million figure in the medicare supplement report is an annual figure, also. If the contingency reserve is used for another purpose other than claims and expenses, then in any following year premiums have to be increased accordingly to replenish that reserve.

Mr. ACKERMAN. Later today we expect the GAO to testify that OPM has failed to apply the Federal Managers Financial Integrity Act to protect the program from fraud and abuse by insurance carriers. Could you explain why OPM didn't make use of the Financial Integrity Act?

Mr. JULIUS. Mr. Chairman, I think we disagree with that finding, if that is the finding of the GAO. The Federal Managers Financial Integrity Act is an act which is imposed upon the agencies to make sure the agencies have internal control, so that the fraud doesn't occur inside of the agency. OMB guidance on implementing the act explicitly states that the internal control evaluation, improvement, and reporting processes apply only to Federal organizations. However, agencies are cautioned to maintain appropriate oversight and reporting mechanisms with respect to recipients of Federal funds such as our insurance carriers. In the FEHB Program, these mechanisms consist of explicit contractual provisions addressing the use of FEHB funds, specific financial reporting requirements, and an ongoing audit program. These mechanisms obviously work because they have been consistently successful in identifying instances where our requirements were not met. So I think we have a disagreement, if that is their finding, as to whether or not that act applies to our contractors.

Mr. ACKERMAN. We will follow that up with GAO then.

Mr. JULIUS. Yes, sir.

Mr. ACKERMAN. The CRS report found that many FEHBP plans used different UCR charges as the basis for reimbursement. This kind of diversity makes it very difficult for enrollees to compare different plans. Would OPM consider standardizing UCR's?

Mr. JULIUS. I don't now whether we have or not. UCR's are a function of local areas, and also the plans themselves, to determine how much of the UCR they are to pay.

Mrs. KICHAK. We have indicated in our call letter this year that we're going to be working very hard to clarify the language in the brochures as to what the UCR levels are, rather than standardize the level, to provide more information so people can make a better decision.

Mr. ACKERMAN. How does that help people who are doing comparative shopping?

Mrs. KICHAK. They will have a description in their brochure as to how the UCR level is determined and how frequently it is changed.

Mr. ACKERMAN. Is that clarification going to tell them how much in dollars and cents?

Mrs. KICHAK. No, it can't.

Mr. ACKERMAN. Why can't it?

Mrs. KICHAK. Because the UCR level varies. It is going to vary from region to region in the country. There is no way we could put the UCR in a brochure.

Mr. ACKERMAN. But there are people from other regions of the country that may not be enrollees in the same region that they subscribe to.

Mrs. KICHAK. I don't understand.

Mr. JULIUS. Would you repeat it, please, Mr. Chairman?

Mr. ACKERMAN. You don't have to be an enrollee in the same region that you live in.

Mrs. KICHAK. Our brochure is a national brochure, so if you put a California UCR in a national brochure, it would confuse or mislead people in New York, for example.

Mr. ACKERMAN. Why can't you identify what the UCR's are for different regions?

Mrs. KICHAK. We issue the brochure in August. The UCR's change as frequently as quarterly throughout the year. So it set a UCR in August for a period of 15 months in advance would be impossible. Also, there is no way in a brochure that we could include that many procedures. UCR's are for thousands of procedures.

Mr. ACKERMAN. You're saying the UCR's change quarterly?

Mrs. KICHAK. In many plans they do, yes.

Mr. ACKERMAN. So for the same expense that you incur in one quarter, if you have a recurring expense, you're reimbursement could be different?

Mrs. KICHAK. It could be, yes.

Mr. ACKERMAN. For purposes of comparison, if you just took the same quarter, why couldn't you just make all that information available to potential enrollees if they were looking to see what the relative differences were at any particular time? I mean, bank rates change daily, but it gives people a basis of choosing between one and another, the assumption being they will all go up or down relatively the same, but they'll know where they're getting a better buy.

Mrs. KICHAK. But we would still have to provide volumes of information, because a plan could have a higher UCR level for one procedure and a lower UCR level for another procedure. To use an

appendectomy for an example would be misleading. It would have to provide the whole schedule.

Mr. ACKERMAN. I'm not sure that providing people with a lot of information is necessarily a bad thing. Take the report, for instance. Okay, let's move on.

Part of enrollees' premiums are used to reimburse OPM for the costs associated with running the program. Does any portion of that money go back into the Federal Treasury as a result of it not being expended by OPM each year?

Mr. JULIUS. The statute allows the agency to spend up to one percent of the subscription income for our internal expenses. If we do not spend up to one percent, the money remains in the fund, in the employee health benefits fund.

Mr. ACKERMAN. Are you saying the money does not revert back to the Treasury?

Mr. JULIUS. I do not believe so. No. It stays in the fund.

Mr. ACKERMAN. How much of that one percent do you use?

Mr. JULIUS. I would have to check and submit that for the record. I don't know at this point. But the one percent is the maximum.

Mr. ACKERMAN. You don't need more than one percent?

Mr. JULIUS. Obviously, we haven't asked for more than one percent. We haven't asked for that statute to be changed at all.

Mr. ACKERMAN. Insomuch as you haven't, there's an assumption that the one percent may be more than you actually do need.

Mr. JULIUS. That's a possibility.

Mr. ACKERMAN. We would be interested in seeing that number, with an eye towards possibly using that for possible reductions in premiums.

[The information follows:]

For contract year 1988, the one percent collected to finance the administrative costs of OPM amounted to $88.8 million. Of that amount, OPM posted operating costs of $8.4 million or 9.5 percent of the amount potentially available. Under current statutes, the balance of the unused one percent is transferred to individual carriers' contingency reserves at the close of the year in porportion to the amount of subscription charges paid to the plans. By statute, the contingency reserve can only be used to reduce future premiums or to increase the benefits offered under the program.

Mrs. Morella, you've been very patient.

Mrs. MORELLA. Thank you. I'm learning a lot.

The Towers, Perrin, Forster and Crosby report recommended that OPM initiate a number of regulatory procedures to deal with the problems of the FEHBP. Can you articulate what those problems were and what regulatory initiatives OPM has undertaken?

Mr. JULIUS. The report recommended that we take some administrative procedures, one, to better control investment of the funds. In respect to that particular problem, what we did was to introduce a letter of credit system where we now hold the reserves, the carriers no longer hold the reserves. We invest them and provide the carriers the money they need on a letter of credit system. When a carrier needs money to operate, pay the claims, he calls our letter of credit system and the funds are provided to him at that point.

The report also suggested that we be more aggressive in looking at plans that have less than 300 members over a period of two

years. Last year we held hearings, and as a result of those hearings several carriers were terminated. We will hold hearings again this year and terminate carriers.

Of the things they suggested, those are two that we have been able to implement so far. The others are still under consideration.

Mrs. MORELLA. And you have taken out of the program those carriers that had under 300 enrollees?

Mr. JULIUS. Within a period of time, a carrier is allowed in the program even if they don't have 300 enrollees, but they need to have 300 enrollees within a two-year period to stay in the program.

Mrs. MORELLA. You indicated, of course, the need for reforms in the FEHBP. I wonder what reforms you might be suggesting, if you're prepared to comment on that at this time, and also how they would mesh with President Bush's budget proposals. It seems to me the latter may just increase enrollee costs in the FEHBP. I wondered also what effects that would have on the risk segmentation.

Mr. JULIUS. At this point we have not ruled anything in, ruled anything out. We have no specific proposal, so it will be a little difficult to answer your question.

I think what we have done so far is to identify what we believe are the major issues where one needs to make decisions in this area, and they are what is the treatment of annuitants, what should the Government cost be, what is the role of employee organizations, should one self-insure or not self-insure, and how do you manage choice. That's what we've done and that's where we are at this point. We just do not have a specific proposal, nor even the outline for one.

Mrs. MORELLA. Do you want to comment on the President's proposal for the reform with regard to what it would cost enrollees?

Mr. JULIUS. I'm not aware of the President's proposal in this area. The only proposal I'm aware of is the proposal in the 1990 budget to change the formula.

Mrs. MORELLA. Right, to change the formula. That would have an impact, obviously, on enrollees.

Mr. JULIUS. That is essentially the question of what should be the Government's contribution.

Mrs. MORELLA. So this is something you're going to continue to be looking at with us.

Mr. JULIUS. Yes.

Mrs. MORELLA. I understand that OPM also has released its report concerning offering medicare supplemental plans to Federal annuitants. What about the contents of that report? Can you give us any highlights? I think it just came out a couple of days ago.

Mr. JULIUS. What the report basically says is we could certainly do better in our treatment of annuitants under the program. However, we don't believe that we should move them into a medigap situation solely and in isolation of everything else. We believe that other alternatives may occur as to how annuitants ought to be treated, if we look at the whole reform package. I mean, that's the conclusion of the report. So the report does not support doing that and that only.

Mrs. MORELLA. Under the current system, employee organizations are allowed to recruit enrollees from outside the organization.

These outside enrollees are allowed to participate in the plan if associate membership dues are paid.

Do these associate membership dues have any impact on the structure of the plan that is offered by the employee organization?

Mr. JULIUS. Not to my knowledge. The money that employee organizations receive in associate dues goes into their fund and is not a part of the FEHBP. I do not know what the employee organization does with associate member dues.

Mrs. MORELLA. I wondered if the same plan could be offered to employees but for the additional cost of an associate membership fee.

Mr. JULIUS. To do that would raise the premiums and it may discourage employees from joining those plans.

Mrs. MORELLA. How does the presence of a plan's high and low option affect the occurrence of risk selection or segmentation?

Mrs. KICHAK. We see, year after year, in plans that have two options, a steady movement of people from the high option to the standard option. When that happens, the high option invariably loses its better utilizers. Where people who have claims at the low range of claims move out of the high option, that means that the premiums in the high option go up because the less expensive people have left.

Also, usually, when these folks move to the low or standard option, they have a higher average claim than the folks that are already there, so at the same time they make the average premium in the standard option go up.

Mrs. MORELLA. Let me tell you, every year during "open season" for health benefits, I have a forum, as do many other Members, and we attract up to 2,000 people who come with these very questions with regard to high option and low option and escalating premiums. So it is something that is important to everyone.

Mr. Chairman, I would like to ask unanimous consent that the questions that have been presented to me by Mr. Gilman, who couldn't be with us today, for OPM and CRS and GAO, be submitted for the record for responses.

Mr. ACKERMAN. We will place those questions in the record. Would you like those responses to be in writing?

Mrs. MORELLA. Yes.

Mr. ACKERMAN. Without objection.

Mr. JULIUS. We will do so, Mr. Chairman.

[The questions follow:]

United States
Office of
Personnel Management

Washington, D.C. 20415

JUN 30 1989

In Reply Refer To

Your Reference

Honorable Gary L. Ackerman
Chairman
Subcommittee on Compensation
and Employee Benefits
Committee on Post Office and Civil Service
U.S. House of Representatives
Washington, DC 20515

Dear Mr. Ackerman:

This is in response to your letter of May 30, 1989 which transmitted two questions from Representative Benjamin Gilman about my testimony before the Subcommittee on Compensation and Employee Benefits.

Enclosed you will find my response to those questions. I regret the delay of this reply, but I did not receive the questions until June 23.

Thank you for your interest in the reform of the Federal Employees' Health Benefits Program.

Sincerely,

Jerome D. Julius
Acting Associate Director
for Retirement and Insurance

1 Enclosure

1. How well do cost control measures, such as utilization review, work? Are savings achieved in the long run as well as the short run? What other type of cost control measures would be well suited for the FEHBP?

Believing that utilization review was cost effective, OPM has encouraged and welcomed proposals to incorporate utilization review as a cost containment measure in various plans in our program. However, we are now faced with escalating administrative costs which include the costs of administering the utilization review programs and inconclusive data to analyze the effectiveness of these programs. Therefore, we surveyed our plans to collect information and supporting data on the value of utilization review and other cost containment measures. We are in the process of reviewing the survey responses. Although it is too late to effect the negotiations of the 1990 rates and benefits, our analysis of the survey responses will be a factor in the formulation of OPM's policy for the 1991 negotiations.

2. Presently, what long-term or extended care coverage is available under the FEHBP? Do any of the plans offer coverage of skilled nursing care while the patient is at home? What would be the costs of a proposal to reimburse Federal employees for lost wages or income should that employee decide to stay at home and take care of a sick dependent in lieu of hiring skilled nursing care?

As the name implies, long-term care is custodial care provided for an extended duration for chronic illness. Payment for such services is not easily incorporated into the FEHBP because the health program is designed to cover acute illnesses. Long-term care is best funded over an extended period of time in a manner similar to the funding of a long-term disability benefit. Annual funding of the type found in our health contracts and open season enrollment shifts increase costs substantially by

preventing the accumulation of assets necessary for making periodic recurring payments. OPM reviewed the cost impact of incorporating long-term care coverage in the health program and found that neither the government nor the employees could bear the immediate and substantial cost of paying for benefits which are best provided for through an asset accumulation.

Under the FEHB Program, care for conditions that are serious but not serious enough to require an inpatient setting is provided through a variety of benefits, such as in-home skilled nursing, Skilled Nursing Facilities (SNF) or Extended Care Facilities (ECF); Home Health Care (HHC) by visiting nurses, home health aides, and/or social workers; and inpatient and/or outpatient Hospice Care for terminally ill patients. Of the more than 350 FEHB prepaid plans (often called Health Maintenance Organizations, or HMOs), all provide SNF care and all but five offer HHC. Similarly, of the 32 plan options available through the two government-wide plans, the 11 employee organization plans which are open to all Federal employees, and the nine employee organization plans which are open only to the organizations' members, 28 options offer coverage of skilled nursing in the home; 16 of SNF or ECF; 22 of HHC; and 31 of inpatient and/or outpatient Hospice Care. Generally, these coverages are provided with dollar, day or visit limits. Long-term nursing (custodial) care is not provided by any FEHB plan.

We could not estimate the costs of reimbursing Federal employees for lost wages or income should that employee decide to stay home and take care of a sick dependent in lieu of hiring skilled nursing care. Such costs would depend on indeterminable varying factors, including: which and how many employees might be affected, the possible range of time frames to be included in a reimbursement plan, the amount of assistance from other family members which might be available or required, and so forth.

Mr. ACKERMAN. Mr. Julius, thank you very much, and thank your colleagues. You have shed some great light on today's hearing. We appreciate your being with us.

Mr. JULIUS. Thank you, Mr. Chairman.

Mr. ACKERMAN. The next panel is Dr. Dennis Snook, FEHB Team Leader, the Congressional Research Service. Dr. Snook, let me begin by complimenting you and your team on the comprehensive and significant contribution that you have made to the discussion of the problems facing the FEHBP and the possible development of legislative reform of the program. I know that you and your staff have spent many long hours and considerable resources in producing this report.

Chairman Ford and I wanted to enlist the best minds available when we asked the Congressional Research Service to review the FEHBP, and we have not been disappointed. At least in this room, your book is a best seller. I think more people here are reading it than Salman Rushdie's book. I don't know if it's going to be as controversial, but I guess we'll find out from the reviews.

Welcome. Please introduce your colleagues.

STATEMENT OF DENNIS SNOOK, FEHB TEAM LEADER, CONGRESSIONAL RESEARCH SERVICE; ACCOMPANIED BY FEHB TEAM MEMBERS JANET LUNDY, MICHAEL O'GRADY, DAVE DELQUADRO (CBO), SHEILA SMYTHE (GAO), AND EDWIN HUSTEAD, HAY/HUGGINS CO.

Dr. SNOOK. Thank you, Mr. Chairman. We do appreciate the opportunity to appear before your committee to present our report. I would like to begin by introducing the members of the panel.

To my left is Dr. Michael O'Grady, Edwin Hustead of Hay/Huggins, and Dave Delquadro of the Congressional Budget Office. To my right is Janet Lundy of CRS, and Sheila Smythe of the General Accounting Office.

I would also like to take the opportunity to introduce the members of the team, who as you mentioned spent many long hours producing this report in a fairly short period of time, and who did so in addition to their regular duties. We have Vee Burke, Brenda Freeman, Thomas Gabe, Geoff Kollmann, Carolyn Merck, Bruce Mulock, Susan Schillmoeller, Ray Schmitt, Eileen Shapiro, James Storey and Mallary Stouffer, all of whom gave considerable amounts of their time to make sure this report could be produced in time to meet today's deadline.

Mr. ACKERMAN. Like the credits in a movie, the unsung heroes.

Dr. SNOOK. That's true. As a matter of fact, Brenda Freeman developed a method of presentation that, in doing so, committed her to working many times during the night in order to produce drafts in time for people to comment on them in the morning. If she hadn't been willing to do so in the finest traditions of public service, we could never have made the print deadline.

Mr. ACKERMAN. We're glad that you called all of their efforts to our attention, and we're glad to include their names in the official record.

Dr. SNOOK. Thank you, Mr. Chairman.

In addition to the members of the team, we also received a considerable amount of assistance throughout the period of the study from technical staff at OPM, advice from various people on that staff, along with a considerable amount of cooperation from employee organizations attached to the Fund to Assure an Independent Retirement. They gave us what we needed at the time we needed it. We also received considerable assistance from various plans and carriers. This was a study that many contributed to and we were very happy to produce it.

Mr. Chairman, one year ago you asked CRS to undertake a review of the Federal Employees Health Benefits Program. You asked that we accomplish four objectives. First was an examination of the current program, clarifying its strengths and weaknesses; second, a comparison of FEHBP to the practices of large private employers and State governments; third, the development of a definitive framework for analyzing the various plans and practices which would be based on methodologies that could quantify cost and benefit alternatives; and standardization of the terms and concepts pertinent to a legislative initiative, and development of presentation techniques so that comparisons could be understood.

As you requested, CRS conducted a study of FEHBP and compared it to the practices of other large employers. In order to examine relevant aspects of the issues in health insurance coverage, we developed a methodology that makes it possible to compare the cost, benefits and enrollment patterns of various FEHBP alternatives. These different approaches to providing health insurance can be examined for enrollees, for plans, for the Federal Government, and for the program as a whole. After our opening statement, if you wish, we could be happy to further explain the capability we created for your use.

For today's hearing, we thought it might be useful to the committee if we reviewed some of the findings from our study, together with some general issues raised by them.

Mr. ACKERMAN. Dr. Snook, let me just state here that I am expected for a vote at 20 minutes after. Rather than delay this group any further, it is my intention that the hearing continue. In the spirit of the bipartisanship that I mentioned at the beginning—perhaps we will be breaking precedent here—but I will be asking Mrs. Morella to assume the chair.

Dr. SNOOK. That would be fine.

Mrs. MORELLA [presiding]. Thank you, Mr. Chairman.

I'm sorry for interrupting you. Please continue.

Dr. SNOOK. For further reference, these findings are listed on the first two pages of the report overview, which we have duplicated for distribution today, accompanied by certain other materials that might be helpful.

Thirty years ago, Congress created a comprehensive health insurance program for Federal employees. FEHBP insures participating employees and retirees against financial hardship arising from costs of medical services. When enrollees or their covered dependents use medical services, part or all of the cost of those services can be paid by the program through one of its subsidiary plans. The cost of the program is shared between enrollees and the Government.

Before enactment of the program, Federal employees were generally responsible for securing their own health insurance. While some agencies offered group health insurance plans, there were no Federal contributions to those plans. A few employee organizations offered group health insurance to their members. Other employees purchased their own health insurance or were covered through the dependent provisions of their spouse's health insurance. Most had no health insurance.

Congress enacted the FEHBP legislation in 1959, and the following year, Blue Cross/Blue Shield and the Aetna Life Insurance Company created Government-wide health insurance plans, each with two levels of benefits. Employee organizations were authorized to establish plans for their members, and 13 organizations offered such plans. Also participating were 21 health maintenance organizations (HMOs), described in the law as "comprehensive medical plans."

In FEHBP, "fee-for-service" (FFS) is the term used to describe plans in which the individual is relatively free to obtain services from a provider, whose charges are then a basis for a claim for insurance payment. These are contrasted with HMOs, which generally are contractual arrangements between various medical service providers, who then provide nearly all the services for the group of people participating in that HMO.

By 1989, the program has grown to include 30 different FFS options that directly insure participants for covered services, and nearly 440 HMOs. Employee organizations sponsor 26 of the FFS options. Each employee and retiree actually chooses from no more than 37 options, and no less than 21 options, the difference primarily determined by the number of HMOs available in the individuals' local area.

There are 2.5 million employees, 1.5 million annuitants, and 5 million dependents in the program. About 450,000 eligible employees elect not to be covered by the program, thus forfeiting their share of the Federal employer subsidy to FEHBP. Most of these people are covered through some other health insurance, often provided by the employer of a spouse. Retirees not participating in the program during the 5 years before retirement are ineligible; about 500,000 annuitants do not participate in the program.

The program is administered by the Office of Personnel Management (OPM). Although OPM has some influence over the benefits in individual plans, each plan is relatively free to design a package of benefits to appeal to enrollees during the annual "open season." The plans estimate premiums based on their anticipated costs for the upcoming year. In 1989, the total cost of FEHBP will reach $11.6 billion, of which the Federal Government (including the U.S. Postal Service (USPS)) share will be about $8.2 billion. Enrolless will pay a total of about $3.4 billion in their share of plan premiums, about 29 percent of the total program cost.

The Government share of each plan's premium is determined on the basis of the premiums for six large plans, two of which are included regardless of size. The Federal share is a dollar amount equal to 60 percent of the average premiums for the Big Six. In 1989, the Federal share of total premiums averages 71 percent, because of the high premiums for the two statutory plans. Postal

workers, whose collective bargaining agreements with the USPS provide for an employer share of 75 percent of the Big Six, have an average USPS contribution of 87 percent of the total average premium.

Madam Chairman, most major FEHBP issues arise from the following three distinguishing characteristics of the program:

First of all is the existence of choice. There is no where near the range of choices available to any other employees in any other program in the country. The program gives participants a choice among a wide variety of individual plans that are relatively free to compete for participants by offering benefits at competitive premiums. This array of choices has led to a very uneven distribution of benefits and burdens among program enrollees. Some enrollees are uncertain or confused about the comparative value of different coverage, and some choose plans with difficult to recognize financial exposure.

This situation has raised three policy questions: does choice serve a useful purpose in the program; should FEHBP strive for more uniformity in benefits and a more equal distribution of enrollee costs; and is it the Federal Government's responsibility to protect its employees and retirees from unwise choices?

This report makes the following points concerning the existence of wide choice in FEHBP:

Choice among many plans in FEHBP gives workers and retirees an opportunity to elect plans that most closely match their expected need for medical services. Enrollees can also elect plans that require lower premiums.

These selections are generally in the interest of the individual enrollee, but can be adverse to the collective interests of an insured group. To guard against adverse selection, plans often design benefits to appeal to lower-risk and discourage higher-risk enrollees.

Choice among plans, in conjunction with the method by which the Federal share of premiums is calculated, has resulted in concentrations in some plans of persons with similar risks. This phenomenon is called "risk segmentation."

Risk segmentation has led to substantially different premiums for the benefits of some plans relative to the premiums that would occur if the plans covered the entire FEHBP population. For instance, a measure of standard benefit value shows a range of 41 percent in the value of benefits in FEHBP plans, while the range in their total premiums is 246 percent.

This disparity in benefit values allows some enrollees to gain advantages, the sum of which largely match disadvantages borne by others. Because the Government generally contributes a fixed amount toward each plan, premium differences from plan to plan due to risk segmentation affect costs primarily borne by enrollees.

The evolution of benefit packages makes informed choice difficult. About 16 percent of enrollees are in plans that have scheduled allowances for provider payments that can make financial exposure difficult to recognize. About 34 percent are in plans in which total premiums exceed the standard value of benefits.

The presence of choice among plans does not have a significant effect on total program costs. However, the formula for calculating

the Federal share of FEHBP premiums interacts with choice in a way that causes the Government share to rise.

The second major issue has to do with the treatment of annuitants. Annuitants can participate in the program on the same basis as employees. The presence of annuitants in the program has had significant effects on certain plans. Because they are generally an older group, annuitants use more services. A concentration of annuitants in a plan will skew that plan's costs relative to the value of the benefits, when those benefits are measured against a common program standard. However, when this population reaches age 65, medicare may become the primary payer, thereby offsetting some of the costs of annuitants without medicare.

About one-half of the FEHBP annuitant population is also covered by medicare. In the past, some annuitants have seen this overlap in coverage as a reduction in the value of their retirement compensation package. Their complaints have increased with the passage of the Medicare Catastrophic Coverage Act, and many Federal annuitants think that this law has unfairly burdened them with a tax to support additional coverage that they neither want nor need.

So the treatment of annuitants in FEHBP raises two policy questions: are Federal annuitants treated fairly with respect to health insurance, and what would be the effect on FEHBP and its participants if annuitants were treated separately?

The report makes the following points with respect to the treatment of annuitants:

In the program, the average enrollee pays about 29 percent of the average cost of benefits. This average enrollee share of benefit costs represents about 34 percent of costs of active workers, about 38 percent of costs for annuitants covered by medicare, and about 18 percent of costs of annuitants in program only.

If the Government paid the same share of benefits for annuitants covered by medicare as a group, as it now pays on average for the program as a whole, then their average premiums could be significantly lower.

Many annuitants in FEHBP and also covered by medicare waste thousands of dollars of their own money by being in plans that require high premiums for benefits they cannot use.

Nevertheless, on average, Federal annuitants covered by both medicare and FEHBP have benefit payments from FEHBP that exceed their own premium payments.

The final issue that we addressed at some length in the report is the issue of costs. Compared to the health insurance provided by other large employers, FEHBP places a heavy burden on employees' and retirees' pocketbooks. Yet, in an era of Federal budget concerns, pressure exists to reduce the Government costs for the program, especially in light of the rapid growth in costs of medical services.

Key issues in costs are: are the costs of the program unreasonable to the Federal Government and program participants, and how might program reforms affect those costs?

The following points reflect our team's findings:

Federal payments for health insurance for the average Federal employee are approximately $1,100 per year less than employer

payments for health insurance of a typical private sector counterpart.

Average increases in total program costs over the last 10 years are not unusual when compared to the experience of private sector health insurance plans.

Money could be saved by adopting cost controls throughout the program, and by eliminating unnecessary expenses not related to claims payments.

More effective administration of the program is possible, and incorporating private sector innovations in health plan management could improve its operations.

Major structural change to the program could solve the perceived problems, but would not save money unless it was coupled with benefit reductions, more cost shifting to participants, or direct controls on providers.

We have developed baseline costs for the current program and for a plan we determined to be typical of the practices of other large employers. These two cost poles reflect a useful range of cost and benefit effects so that alternatives to the current program can be compared to recognizable standards. We have included an example here. There are several in the report.

This concludes our oral statement. We would be happy to answer any questions you might have. In addition, we would be pleased to work with the committee to provide an analysis of issues you encounter as you examine the program.

Mrs. MORELLA. I Thank you very much, Dr. Snook, for presenting a program that has been so carefully worked out. I think you presented it today orally in a very succinct manner.

Your conclusions are very interesting and rather provocative, too, in terms of perhaps a few surprises. I didn't quite realize the Federal Government was getting off cheap in terms of being compared with the private sector. The points that you bring out in your findings statement, the fact that average increases and total program costs are not unusual when compared with the private sector; money could be saved by eliminating unnecessary expenses not related—I guess that's what, administration? Do you want to comment on that, or should I read all of this to——

Dr. SNOOK. Oh, no. We can provide some summary comment. Of course, elaboration is available in the report.

Mrs. MORELLA. I realize that.

Dr. SNOOK. First of all, the Federal Government, because its insurance is deployed through particular plans, oftentimes finds those plans are required to pay State premium taxes in States in which they provide coverage for Federal workers. Those premium taxes don't provide the Federal Government or its enrollees with any improvements in insurance. It's money that flows to State budgets.

In the private sector, one of the approaches that has been followed by larger employers that are faced with State premium taxes, among other issues, of course, is that by self-insuring, they are able to avoid such taxes. To a large extent, the Federal Government's program has to be seen as self-insured. There are ways in which the program's legislation could be drafted that would make

that quite clear. If so, then there would be no grounds for providing State premium taxes. That's one.

Mrs. MORELLA. The States aren't going to like that.

Dr. SNOOK. Of course. Some States would resist, although I don't think for any particular State it amounts to a substantial part of their own State budgets.

The second thing is that moving to some arrangement whereby the Federal Government is self-insured would eliminate the need for certain reserves that are maintained now and which are reflected in the premiums. I think Dave Delquadro of CBO included some analysis in his chapter and maybe he would like to comment further on that.

Mr. DELQUADRO. Madam Chairman, the point that Dr. Snook is raising is germane with regard to an understanding of the program as it exists now, and then as how it may be modified under one of a series of policy changes that the Congress may want to consider. The question I think we're addressing, then, is how large do the reserves need to be given the current situation and how might that be modified if the number of plans were reduced or if there was one reserve pool for all of the plans instead of the plan-by-plan approach that now exists.

Mrs. MORELLA. Incidentally, do Maryland or Virginia tax the premiums now?

Dr. SNOOK. I couldn't answer that question right now, Madam Chairman, but we could find that out.

Mrs. MORELLA. I think they may.

You have also commented using private sector innovations in health plan management could improve the operation, so you're talking about administration of the program. There are just so many different programs that are offered.

Have you come to grips with that, maybe reducing the number and incorporating?

Dr. SNOOK. I think the General Accounting Office panel that will follow us has taken a very close look at that. While we did examine the question of how the program is administered and how it might be administered differently, we did so to see what general issues might emerge in the course of structural reform. So we could say that it is apparent that the program, because it has so many different plans, is not the most efficient way to provide health insurance to this large number of employees. It could be more efficiently administered if there were certain kinds of procedures adopted. But I think for a more detailed and explicit elaboration on that, we should defer to the GAO panel.

Mrs. MORELLA. You also talked about major structural changes and making it more efficient, to take care of some of the perceived problems. But the way to reduce premiums would be really to reduce benefits. This may well tie in with the catastrophic insurance, because if you looked into that, the possibility that if, for instance, the prescription drug benefit were not there, it would have significantly reduced the premium.

Is this the kind of thing you're getting at?

Dr. SNOOK. I think what we're trying to show there is, first of all, when you speak of health insurance, the major cost of health insurance is the benefits that are provided to the people that are cov-

ered and the charges that are attached to those services. I think what we're saying is, in the absence of a way to get at either the services that are provided, or the charges for those services, inevitably structural reform will yield the same in total benefits to the existing population or it won't. If it does, then costs are going to be roughly the same for the program.

What we suggest is that there are also some other factors that would have to be considered in structural reform. Two, for instance, are the number of Federal workers who currently do not exercise the option to join the program. There are about 450,000 such workers. If structural reform resulted in a better designed program or a program that was more attractive than the one that exists today, then some of those people would be drawn back in. At the present time, there is no Government contribution on behalf of those people. If they were brought in, there would be. That's one.

The other is, as you mentioned, the medicare benefits. Presumably, the benefits that the annuitant population receives could be designed in such a way that they would be provided through a separate plan. But the question would arise at that point as to the total package of benefits they received compared to the total contributions that were paid in their behalf. If benefits were held constant, then there could be either additional burdens elsewhere in the program, or additional program costs. Reducing the benefits could result in some savings in the total amount that enrollees paid.

Mrs. MORELLA. There is, of course, duplication for many people who are in the FEHBP and who are medicare eligible and, therefore, have the catastrophic. In trying to relieve that duplication, an amendment was finally put into the bill that became law, to give a reduction in premium for those people who have a duplication. I think that amount was ultimately $3.10 a month.

You also comment, in addition to the benefit reductions, on cost shifting to participants. I guess you mean by that those people who use would pay?

Dr. SNOOK. Say the sum of an insurance plan's cost, whether it be an individual plan operating within the program or the total program, is going to be the sum of those benefits. Premiums are those charges divided by the number of people that participate. If the benefit total remains the same for the entire population, then, unless some of those charges for those benefits are passed back to the enrollees, the program wouldn't have any difference in total cost.

Mrs. MORELLA. Finally, you comment on direct control on providers, a very provocative phrase, and maybe that is an important point upon which you might want to elaborate for the record.

Dr. SNOOK. At the present time there are a variety of controls that are exercised at the plan levels, to try to determine whether or not the plan is using services that it does not need to use. For instance, there are second surgical opinions that are intended to determine whether or not an actual surgical procedure is indicated in the particular case.

Some of these things are thought to reduce the climb in health costs and, therefore, in health insurance premiums. There could be more thorough use of utilization review, various kinds of case man-

agement, various approaches to reducing the level of services or attempting to more directly limit the charges. What we have done is we have suggested that it's possible to do that. The profession of reducing health care charges or services is an unfolding one, and what we're suggesting is that over the course of the legislative phase, it would be possible to more completely analyze the kinds of things that are being considered in various plans around the country today.

Mrs. MORELLA. I understand also that you have elaborated on that in the complete report. Many of us did not get the report until just this morning, so we will be back in touch with you specifically and working with all of you on that.

I am also curious about how you respond to the weighted average approach for computation of the Government contribution, as was suggested and brought up with the previous speaker, in the administration's fiscal year 1990 budget resolution.

How would it affect the risk segmentation that you talk about, that we currently have, and do you see benefits or liabilities in using such an approach in a reformed FEHBP structure?

Dr. SNOOK. Certainly the current formula contributes to risk segmentation, because it assures that there is less paid by the Government to some plans than to others, and it assures that individuals pay in some cases higher premiums for the same value of services than others.

Because two particular plans, the high options of Aetna and Blue Cross/Blue Shield, have had steadily increasing premiums, the effect of the current Big 6 formula is to cause the Government's average share of the program to rise. If that was changed, following the approach taken in the President's budget for this year, it is not clear that that would affect existing risk segmentation, but it would have the effect of changing the share of total premiums paid by the Government. While this would cause Federal outlays to be reduced, it would be met by a corresponding increase in the burden on enrollees.

Mrs. MORELLA. You have a part of the team, some of the critical people here with you. Would any of them like to add any comments to the discussion?

Dr. O'GRADY. On the point that was just made about the proposal to go to a weighted average, there are two components there that should be kept distinct, in my opinion anyway. One is the idea of going to a weighted average so that the Government doesn't—if you're looking at a cost increase and the Government's share goes up by 26 percent, whereas the employees are only going up by 22 percent, where you have something where the Government is kind of—where OPM is crying foul to a certain degree, that they're having to absorb more of the increase on the Government's share because of the way the Big 6 formula works—they certainly have an analytic point there.

The idea that if you wanted to go in and take it currently now at 60 percent of the Big 6 at a maximum of 75, we found that that basically shakes out to being about 71 percent is paid by the Government and 29 percent by the employee. You could go to a weighted average, and at the same time there's nothing that says that that has to be linked still back to 60 percent. With that kind of a

constant cost situation, you could go to a computation that would no longer be, as OPM might put it, a disadvantage to the Government. At the same time, it would not at that point be shifting a fair chunk of the burden over to the employees. It would simply make the future increases in cost equally borne by the Government and the employees.

There are two components there that often are not distinct in the administration's proposal.

Mrs. MORELLA. Anyone else want to make any comments, things that you think have been omitted that you want to comment on?

When you're doing your compilation and as you prepared your strategies for reform, did you work with OPM and GAO? I mean, do you communicate among each other?

Dr. SNOOK. Yes, particularly as we began developing data bases for analysis and the techniques for analyzing the data. In fact, Michael could go into that a little bit. There were considerable periods of time there when we worked with other people who are familiar with the problems in order to produce as complete a methodology as we could.

Dr. O'GRADY. When you think about what we tried to develop for the committee—and this is a product of it, but not necessarily the only product—we consulted considerably with OPM. Most of the data that this is based on, certainly the demographics of the Federal work force, are almost exclusively coming from OPM. Some of it is also coming from census data. We also consulted with private sector actuaries to be sure we knew the benefit designs and interactions of what the private sector experience has been as you change deductibles, coinsurance, that kind of "nuts and bolts" of what goes into a health package.

But OPM, especially as compared to our experience at the time of the retirement research we did with FERS and CSRS, has been quite open and quite cooperative and very helpful, as simply another crew of analysts to call up and bounce an idea off of, who have experience and some fairly good insight into this program. And certainly GAO and CBO have been consulted throughout.

Mrs. MORELLA. Does anyone else have any comments they would like to make?

Mr. HUSTEAD. Yes. I think the important thing to keep in mind as you review the program is that it was written, drafted and created in 1959, 30 years ago, and basically has not been changed structurally since then. In the meantime, the insurance world has changed tremendously, inflation has hit on the insurance market. I think the good elements of the program, the choice elements, and the ability to choose each year, can be retained under a much simpler and modernized structure. We fully endorse the bindings in the conclusion and look forward to the work the committee will do with it.

Dr. SNOOK. I think, if there is one thing that we think deserves going into in some additional detail, it is some of the analyses done of annuitants. We were fortunate in this study in having Janet Lundy join us, because she had worked throughout the development of catastrophic legislation and, in addition to her other roles in the health section in CRS, she has worked on FEHBP issues for a good number of years.

Janet.

Ms. LUNDY. It was unfortunate that the timing of the OPM report was released so close to the time of ours that we haven't been able to do an extensive analysis of that report. But it is pretty clear that the issue of offering separate medigap policies to medicare-eligible annuitants must be looked at in the context of its impact on the rest of the FEHBP program. Annuitants represent a sizable portion of FEHBP enrollees. They are about 40 percent. The annuitants without medicare represent a considerable cost on a per individual basis to the program. Their costs are about twice that of an active enrollee in the program.

Because medicare is the primary payer, the 70 percent of annuitants over age 65 who have medicare coverage represent a cost to the program that's about equal to that of the active enrollees. So, depending on whether you're talking about annuitants with medicare or annuitants without medicare, you're talking about different cost impacts on the rest of the program.

Now, if you consider removing the annuitants with medicare from the program by offering them or requiring them to go into separate medigap policies, the impact on the program could be considerable. The costs could go up both to the Federal Government, because of the impact on the Big 6 calculation of removing these annuitants with medicare from the pools of the Blue Cross and Aetna high option plans, and also the impact on the rest of the enrollees in the program. Their costs would go up. OPM has documented that in their report under the three scenarios.

The equity of removing the annuitants from the rest of the pool can be looked at in two ways, both the equity to those individuals to allow them to purchase separate medigap policies, and the equity for the rest of the program, which is a risk pool concept. Removing them from that pool would certainly have an impact.

Mrs. MORELLA. I didn't ask you about long-term care, but that is something again that these annuitants and all of them are looking to in the future. That will be a big problem.

I want to thank you very much for not only the presentation but the work that went into this whole strategic booklet, this volume that you have here.

I am going to suspend the meeting so that Mr. Ackerman will be able to come back momentarily, because I know he wants to ask you questions. I personally have had a health care association waiting in my office with a TV camera for a half-hour. But I do want to let you know how sincerely we appreciate the work that you have done. I want to personally thank Janet Lundy, Michael O'Grady, Dave Delquadro, Sheila Smythe and Edwin Hustead and, of course, Dr. Snook, for making the presentation.

So if you could just be at ease—I guess he's on his way, so it will be a few minutes. But I don't want you to leave so that he can ask further questions.

Dr. SNOOK. Thank you, Madam Chairman.

[Whereupon, the subcommittee was in recess.]

Mr. ACKERMAN [presiding]. The subcommittee will come back to order.

Dr. Snook, I suspect that the most frequently quoted line from your report will be that "choice does not significantly affect

FEHBP's total cost." Even though you make clear that choice leads to adverse selection, which leads to spiraling costs in certain plans, some people may interpret your report as saying that there are not too many plans.

Would or would not they not be misinterpreting your report?

Dr. SNOOK. I think they would be substantially misinterpreting what we're saying. First of all, I think one of the major confusions that exists with respect to the effect of choice on costs is to not distinguish between FEHBP as a population of people, insured for medical benefits, as a matter of public policy, and individual plans which provide insurance to subsections of that population.

When we say that choice, in itself, does not substantially affect program costs, that disguises the fact that many people are therefore paying disparate amounts of their own premiums in return for benefits that could be considered substantially the same.

While there is some difference in the value of benefits from plan to plan, there is nowhere near as much difference in the value of benefits as there is in the total value of premiums. That does raise again that question, why would public policy permit the participants benefiting from that policy or participating in that policy to have such widely divergent results. So that's one thing that I think people have somewhat misunderstood about that.

The other is exactly why it is that choice remains somewhat neutral in cost for the total program as a whole. An intuition is that some individuals in the program shop benefits—that they actually move to a plan based upon that plan having a particular benefit that they believe they will need. What we found was that, while that intuition was correct—there are people who are able to accurately anticipate the benefits that they will use during the upcoming year and move to plans in pursuit of that particular benefit—there are far more people who move as a result of not getting the value of benefits in the plans that they're in for the premiums they pay and they leave in pursuit of lower premiums.

Now, what we did in order to actually get to the question of whether choice affected costs, we standardized the population and applied that standardized population to each plan to create a common framework for evaluating particular plans benefits.

What we found is that if you have, in a sense, that conceptual ideal of a typical FEHBP plan, there are enough people who move through the FEHBP catalog of plans down into plans that have lower total benefits from plans in which they would have been better protected. There are savings attached to those people having actual risks that they did not have before manifest themselves in lower benefits at the time they need them. So while it is correct to say that there are some people who are able to receive benefits from plans that they have chosen to enroll in specifically for those benefits, there are enough people who receive losses as a result of having moved to avoid risk segmentation and benefit cost, there are enough people who received losses to offset those costs. So the total effect of choice on cost is relatively insignificant.

Mr. ACKERMAN. Last year the TPF&C report claimed that the FEHBP could cut its costs from $500 million to $785 million by implementing a number of administrative and legislative changes.

Has the CRS review of FEHBP confirmed the consultant's projected cost savings?

Dr. SNOOK. I think I will defer that question to Dave Delquadro of CBO, who spent many months examining the questions of costs in different categories.

Mr. DELQUADRO. Mr. Chairman, the numbers I have in front of me add up to the $785 million total. I would just go through them one by one, if I could.

We did not address the fees paid by individuals who elected to join employee plans, so the $25 million is beyond the scope of our study.

The $200 million savings in administrative costs referred to by TPF&C as an OPM estimate, again, this was not an area that we went into in great detail. I believe the TPF&C report identified duplication of actuarial services, computers, things that could be considered core overhead. That number I would leave to GAO to interpret.

On the cost-containment side of $240 million, which was predicated on the three percent savings, I believe—and I would like to refer to Ed Hustead to comment—I believe that we're assuming that an aggressive cost containment effort could slightly surpass that estimated savings.

Mr. HUSTEAD. I think certainly the finding there and in CBO studies and elsewhere is that if we use this $11.6 billion total premium to really get at the costs at the source of their cost, through such programs as DRG's, without recommending any particular approach—because that changes year to year—but if you did that, you could save substantially in the area of these costs.

Dave mentioned the $200 million of administrative expenses. This is qualified in the TPF&C report by saying if the costs throughout the program were at the same basis as the lowest cost programs, and that certainly is true, that if you did the least effort on administration, you could save $200 million. But I think you should keep in mind that throughout the CRS report and other commentators, the point is made that really more should be spent on administration than is being spent. So the $200 million is not savings, I think, that would be good savings. It should really be spent.

Mr. ACKERMAN. Your report makes clear that the Government is already getting by cheaper than most private companies when it comes to health insurance. Are we supposed to conclude, therefore, that we should not be looking at reform of FEHBP as a way of saving the Government money?

Dr. SNOOK. I think that what drives comparisons to the private sector is an implicit economic assumption that the Federal Government competes for employees with other large employers, and that in the sense in which there is such competition, the total compensation received by employees in the Federal Government and employees in the private sector is a factor in the decisions that employees make with respect to which jobs they take.

When we have said that the Federal Government's health plan, for the average Federal worker, is about $1,100 a year less than the typical private sector employee would receive, it points to the differences in overall compensation policy. Because we anticipated

that there would be some interest in where health insurance fits in the Federal configuration of benefits, we asked Ed Hustead if they could update the compensation comparability study that they did for this committee some years ago, four years ago. Maybe he could elaborate on this.

Mr. HUSTEAD. If we think back to the retirement study we did, at that point the issue was, when you combine all fringe benefits together, are they better or worse than the private sector. The answer four years ago was that they are slightly better. We pointed out then that the health plan was not as good as the private sector, but retirement plans were better, leave was better.

We found over the four years that have intervened that actually the private sector has gotten better in many fringe benefits and the Government has either held constant or declined. So now you have a program where the health benefits program is notably below the private sector. The employees pay more and get less in benefits. This is no longer offset by better retirement benefits and better leave. So you have a total benefits package that, for new employees certainly, under the Federal Employees Retirement System, is not as good as the private sector. Particularly noticeable is that the health plan is well below the private sector.

Mr. ACKERMAN. All three of the illustrative strategies mentioned in your report assume that the FEHBP would be self-insured. Why do you make that assumption and what are the primary consequences of moving to a self-insured program?

Dr. SNOOK. As I mentioned, this is, first of all, a matter of public policy. FEHBP is health insurance for Federal workers and it is a matter of public policy to provide that health insurance to those workers.

Consequently, it is involved at the very core of the Federal Government's relationship to the private sector because it is such a large program. For all practical purposes, over the period of time of the program's evolution, the Federal Government has taken steps to assure some administrative control over the way in which that money goes in and out of the Government to provide health insurance. In effect, we have evolved to the point where we are fairly well established as self-insured now.

There is very little risk on individual plans because they have an opportunity to recover their losses, and there is very little opportunity for profit because they have the requirement that they pass on their gains. So given the absence of the normal kinds of things that one would associate with insurance in the private sector, there is instead——

Mr. ACKERMAN. Excuse me, Doctor. When you say there is very little chance for profit because they pass on their gains, you're saying they're not operating profitably, or are you saying they have a fixed profit?

Dr. SNOOK. Yes, they have a fixed profit, or limits on their profits, I think is a more accurate way to say that. I'm saying that a plan isn't free to simply compete in this pool of workers by offering a package of benefits at a particular premium, and if at the end of the year they have far higher premium income than they had in benefits, they don't get to pocket the difference. They have to pass it back in in subsequent years.

The same is true if they lose. If they have less in premium income than they actually have in benefit experience——

Mr. ACKERMAN. Just expand on that. You say they pass it back in subsequent years. Who gets that money?

Dr. SNOOK. That money is rolled back in the following years in lower premiums. So that their ongoing relationship between the premiums they charge and the benefits they——

Mr. ACKERMAN. You say they pass that through in the form of lower premiums?

Dr. SNOOK. The basis for——

Mr. ACKERMAN. Is there any citation that premiums were ever lowered?

Dr. SNOOK. I think they're lower than they otherwise would be. You know, one of the things that happens in health insurance is that the target for anticipating an upcoming year's costs is always a moving target, particularly in this program. What the carrier has to do is estimate, based on the package of benefits that the carrier has, what those benefits will yield in the way of charges in the upcoming year, which means first of all they have to build in an inflation factor for just general inflation in the economy; the second thing they have to do is build in an inflation factor for medical services, which are increasing at a rate faster than the general rate of inflation. The third thing they have to do is they have to anticipate what the enrollment will be in that plan based upon previous experience and based upon changes they are making. So they estimate a premium based upon their expectations.

Now, when those expectations are not borne out, either on the high side or the low side, that adjustment is then made in the following year or in subsequent years, within some range of considering whether the plan can remain competitive within the FEHBP marketplace.

Mr. ACKERMAN. Your basic point is that, regardless of what combinations of permutations and guesses and scientific logic they use to make their projections, they're basically completely risk free. If they lose on the toss of the dice, they pass it through next time, and if they win they don't get to keep it anyway.

Dr. SNOOK. Right.

Mr. ACKERMAN. And then, as a matter of fact, the Government is, de facto, self-insured and therefore we don't need these guys.

Dr. SNOOK. Well, I hesitate to——

Mr. ACKERMAN. I think that is the conclusion.

Dr. SNOOK. We will agree that they are, de facto, risk-free, and that the Federal Government, as a result, is for all practical purposes already self-insured.

Mr. ACKERMAN. So you're saying then, as a matter of public policy, we can look to the Government taking over a function performed by private enterprise because their profits are fixed?

Dr. SNOOK. Profits are limited, and there is some interest in plans, as institutions or organizations, in improving their market share. They have normal organizational imperatives for increasing the number of people that they cover, partly because their costs in many cases are extremely sensitive to the economies of scale. If they have more people——

Mr. ACKERMAN. Are you saying that the larger plans are more profitable on a bottom-line basis than the smaller plans?

Dr. SNOOK. On the basis in which they employ people administering the plan, they have the capacity to expand their organization as organizations as a result of having more people. There is, as I say, incentive to expand their——

Mr. ACKERMAN. Expanding their organization, my question was, does that give them more dollars?

Dr. SNOOK. More dollars to use in ways in which an organization uses them, but not more money that they can return to the hands of the organizers in the way of profit. Their profits are limited in the program. I think the estimate that we're using is they run somewhere between 0.6 and 1.1 percent of premiums. That, in itself, is——

Mr. ACKERMAN. Let me just understand the public policy perspective of this.

Are you suggesting that the Government should take this over because it is already assuming the risk and, therefore, is entitled to make the profits, if there are any? Obviously, there appears to be, because there's enough of these guys wanting to stay in the business or get into the business. Or are you saying that the Government should be risk-free and that they should take the risks?

Dr. SNOOK. I'm suggesting that the middle ground that exists now relieves individual plans, for the most part, from a burden to avoid risk in the pursuit of profit. On the other hand, the Federal Government, while it does manage the program's overall finances in such a way that the money passes through the Government to the plans, and, in effect, the Government can establish a relationship that assures that benefit obligations made by a plan can be made good with no additional dollars, that there is, in effect, nothing gained by the program in having the kind of reserve policy which suggests that plans are at risk.

When plans create reserves in the private sector, the idea behind that policy in the private sector is to assure that the plan can meet its commitments. In the Federal Government, it is not clear that the commitment to assure an enrollee of benefit protection vanishes in the absence of a plan's ability to meet its obligations. In addition, there is virtually no experience in the system of, at least the fee-for-service plans, ceasing to be able to operate as a result of operating at a loss for a substantial period of time. Eventually they are able to——

Mr. ACKERMAN. I'm just trying to understand the policy implication for this. It seems to me there are two options in this instance. If the Government is not satisfied because it is taking the risk and holding-harmless those companies that participate, there are two things that can be done. Either don't hold them harmless and have them take the risk, or take them out because the Government is holding them harmless and have the Government take the profits.

Dr. SNOOK. I would agree that those are the alternatives.

Mr. ACKERMAN. I would have guessed before the hearing that the public policy statement that we might hear from the administration is to let private industry do it, and let them take the risk and let them make the profit instead of the Government doing it. I don't know that I have an opinion on it at this point. I just want to

understand that that is the public policy implication, that the Government, because it is taking the risk, rather than asking private industry to take the risk, the Government is instead going to take the profits.

Dr. SNOOK. Let me give you an example of one of the things——

Mr. ACKERMAN. I'm not expressing opposition to that. I just want to understand that that's the position or the policy.

Dr. SNOOK. Well, we're trying to make clear, of course, what the policy alternatives are and what the implications of the approaches are, rather than take a position ourselves. We just want to have it adequately understood.

With respect to this one particular problem, in the past, each individual plan has had to maintain reserves of a certain level as if that plan might cease operation. And yet, practically speaking, you could consider the possibility of risk that a plan might cease operation as to be a risk borne by all the plans in a common pool. One question that would arise is, why is it necessary for each plan to be treated as if there's a possibility it would go out of existence, rather than one common pool that reflected the possibility that one of the plans might go out of existence? That's one. The idea there would be a centralized reserve policy.

But this issue is something we have tossed around a lot, and I would actually want to defer to Ed Hustead and Dave Delquadro, both of whom have pursued this question at great length.

Ed.

Mr. HUSTEAD. I think if you examine the role of the insurers in FEHBP, the main function of the insurer is to process and pay claims. That role will be there whether they are in a pure insurance relationship or not. The insurance relationship is only nominal. As Dr. Snook says, there is no real risk, particularly for the larger plans, and therefore, it just makes sense, if there is an advantage to be gained by no longer calling it pure insurance, then you should do it. The insurance organizations can still be there; they can still administer the claims; they can still promote their policies. There are advantages to removing that insurance——

Mr. ACKERMAN. What you're saying then is that you're willing to divide the risk and the function, and what you're saying is that the Government should take over that part of it, that's venture capital, and turn over the bureaucracy part to private industry.

Mr. HUSTEAD. I'm saying, in effect, the Government already has that role of insuring its own program. They are, in fact, self-insured because all of the reserves are held by the Government; all of the funds come back to the Government that are excess.

Mr. ACKERMAN. How much does the Government stand to gain?

Mr. HUSTEAD. By becoming self-insured?

Mr. ACKERMAN. By taking the insurance people out of the insurance business and putting them in the administration business exclusively.

Mr. HUSTEAD. If you maintained all the plans exactly as they are, it would be hardly noticeable. What you now call risk charge or profit, most of it is still a necessary operational expense.

Mr. ACKERMAN. So you're saying the insurance companies are not making any money on the insurance aspect?

Mr. HUSTEAD. No, they are not. Only a very small amount.

Mr. ACKERMAN. So why does the Government want to do it?

Mr. HUSTEAD. There is no need really to have a large insurance operation, to have a risk. The risk is on the Government and it has been for a long time.

If you put the risk back on the private sector and put it back on the insurance companies, the disadvantage is that they would ask for rates that would be so high that, at least in the initial year, the cost increases would be prohibitive to protect them against——

Mr. ACKERMAN. So you're saying there is no profitability in the insurance aspect?

Mr. HUSTEAD. Not in the way the Federal Employee Health Benefits Program is structured, no.

Mr. ACKERMAN. So basically, for insurance companies, their only profit in this whole operation is in the administering of the plans?

Mr. HUSTEAD. That's correct.

Mr. ACKERMAN. Why would the Government want to take over a function which there is no benefit for the Government to do?

Mr. HUSTEAD. In essence, they already——

Mr. ACKERMAN. I think the Government could at least do the administration of it. There's no risk in that, is there?

Mr. HUSTEAD. No.

Mr. ACKERMAN. And there is a profit in the administering of it?

Mr. HUSTEAD. Not a large profit. It's a very small profit involved. As was said, it's about .7 percent, .6 percent, of the total premium. It's .6 or .7, depending on the plan.

Mr. ACKERMAN. Of the total premium?

Mr. HUSTEAD. Yes.

Mr. ACKERMAN. What is the total premium?

Mr. HUSTEAD. Eleven point six billion dollars.

Mr. ACKERMAN. So it's .6 percent of $11 billion?

Mr. HUSTEAD. Yes, $66 million.

Mr. ACKERMAN. Sixty-six million dollars is the whole profit that is generated by the industry that administers 450 different plans?

Mr. HUSTEAD. That's correct.

Basically, what is done with that money is, a large part of it, is reimbursing them for costs—

Mr. ACKERMAN. And the Government should be anxious to take over all that part of it in which there is zero profit and do all that work pro bono?

Mr. HUSTEAD. No. I'm saying you can leave that function with the insurance carriers in the program. It is just this role of "insurance"——

Mr. ACKERMAN. The risk part.

Mr. HUSTEAD [continuing]. The risk part, which does not exist in any event, can be removed without affecting the cost or the structure of the program.

Mr. ACKERMAN. So these insurance companies are basically getting paid and making money not for insurance but for administering?

Mr. HUSTEAD. That's correct.

Now, really, the self-insurance role here is almost a nominal question——

Mr. ACKERMAN. Did they think they were providing insurance?

Mr. HUSTEAD. No, they don't.

Mr. ACKERMAN. They don't think they're providing——

Mr. HUSTEAD. I suspect, if you ask them, they would say they are not.

Mr. ACKERMAN. Only the public thinks they are providing insurance. The Government is really providing the insurance and assuming the risk.

Mr. HUSTEAD. That's correct.

Mr. ACKERMAN. And the insurance companies are providing administration. It seems to me there's kind of a role reversal here that 11 million people aren't aware of. The Government is an insurance company and the insurance company is a government. The insurance company is making money on the Government and the Government is taking the risk on the insurance and not making anything on it.

Did I get it right?

Mr. HUSTEAD. And what the insurance company is paid is not for insurance but for paying claims, that's correct. This is the way it is with all large private employers. It is not unique to the Government by any means.

Mr. ACKERMAN. Wouldn't the Government want to get into the government business and make $66 million for having people push paper around? We're good at that.

Mr. HUSTEAD. I think you would have to increase the work force by quite a few people to do that, and that may be impractical.

Mr. ACKERMAN. Couldn't we hire the same people and the Government could make the $66 million? We wouldn't have to fire anybody. Maybe we could make less than the $66 million and hire more people. It's just a thought.

Dr. SNOOK. There are reinsurers. Some of the carriers contract with insurance companies to provide insurance beyond the individual plans. There is the possibility that if the program were restructured at a point where one of these major insurance companies had a loss that they had not yet been able to recover, and that the program is restructured in a way that they could not recover that loss, they could be considered at risk for that possibility. But that is a possibility which in the 30 years of the program's existence has never manifested itself for any particular plan.

Mr. ACKERMAN. It's mind boggling to me that an insurance company can make $66 million on bureaucracy and administration, and the government managed to rack up the kind of deficit that we have. Maybe we should change places. I'm glad nobody is here listening.

Mr. DELQUADRO. Mr. Chairman, you raised the question about profits and how it relates to size. I just wanted to comment on the notion that—I'm talking now about the fee-for-service plans, not the HMO's. What is going on is, to the extent you have a limit on the amount of profit, that limit applies to the premiums, the subscription income that is paid for the individuals who enroll. So from the standpoint of, if you have more enrollees, and you get one percent of the premiums paid for each additional enrollee, then you get more profit. You get the same percentage, but it increases as your enrollees increase.

However, if you attract the enrollee who is going to cause your claims payment to go up faster than the average, then your premi-

ums, under the current situation, are also going to have to rise faster than your competitors. So it's a situation where you want to increase your profit by increasing your enrollment, but you don't want to do that at the expense of drawing in higher-than-average risks. So you want your enrollment to increase, but you want it to be below average risk enrollees who join your plan.

Mr. ACKERMAN. Did you just say you've got to fish with the right bait?

Mr. DELQUADRO. It seems that way, sir, yes.

Dr. SNOOK. Mr. Chairman, another example would be a large plan which developed a method for controlling costs, and the actual capital investment up front to create such a methodology or such an approach doesn't change substantially when the numbers of people covered by that process are increased. In effect, their actual expenses per claim would be reduced, and yet their ongoing per claims returns could remain the same over time. So there is an incentive for individual plans, as organizations, to increase their enrollments and thereby returning funds to the organization for uses in ways in which organizations use money—for employees, for procedures, processes, other administrative apparatus.

Mr. ACKERMAN. You answered my next question.

Your report endorses the concept of minimum benefits, or at least minimum standards. One concern which has been raised about that proposal is that it could price lower salaried enrollees out of the FEHBP market. They simply might not be able to afford health insurance.

Is there a way to protect these enrollees while at the same time alleviating adverse selection?

Dr. SNOOK. I think so. I would like to point out that it is not as if we endorsed a particular approach. What we suggested is there are certain kinds of problems which are the most easily addressed by adopting certain other approaches. But Dr. O'Grady has done a good deal of work with his colleague, Tom Gabe, on analyzing not only the impact of the current system by income level in the various plans, but also examining alternative ways in which the concerns of low income enrollees could be addressed in a restructured program.

Dr. O'GRADY. It is true that the situation is such that because you're offering a standard premium being charged to the employee, it doesn't take into account the employee's ability to pay really.

When you take a look at the Federal Government work force and what they're paying, you do find a couple of things. You find that lower income employees do tend to utilize those plans with lower premiums at a higher rate than higher income employees. That shouldn't be a big surprise to anybody.

The other thing you find is, because they're moving into plans that have lower premiums, the amount they are getting from the Government, the Government contribution, tends on average as well to be lower. So they are getting less from the Government, they're moving into cheaper plans, and at the same time they're spending a higher percentage of their total income on health premiums than a higher paid employee, even if they're in lower costing plans.

There are any number of moves that the committee could make and consider if they wanted to try and address this kind of a problem. Certainly tilts in different types of—doing things with the Government's share of the premium, having to adjust those based on the employee's ability to pay or perceived ability to pay. There are moves that could be made and explored, and we would be more than happy to knock around two or three ideas to see what would go on.

There are some things you do want to be careful of when you get into this area. What do you want to do with part-time employees? What do you want to do if you want to make it easier for your low income employees to be able to afford the premium, and you started to move around the Government's share, the implication would be that higher paid employees would probably have to pay more, unless you wanted to increase total Government cost. There are certainly moves you can make there. We would be more than happy to explore a number of different options for you. Something can be done there, but none of it is totally painless.

Mr. ACKERMAN. Your book mentioned that about one-half of the private sector firms used health promotion activities. Is FEHBP doing enough in areas such as smoking cessation, stress management, control of obesity, and would it be cost effective to do more?

Ms. LUNDY. I'm not sure we would be in a position to evaluate whether they are doing enough. The activities that the Federal Government does in this area—employee assistance programs for alcohol and drug abuse and other health promotion programs—are separate from the insurance function that is performed through FEHBP.

The studies that have been done of the impact of these various health promotion programs, smoking cessation programs, are not conclusive. There are reasons for that. It's hard to hold constant all the variables you would need to hold constant to assess just the impact of the participation, the individual's participation, in one of these programs. Also, the impact of involvement in one of these programs, any impact it might have, would probably take place over a long period of time, longer than the studies might capture.

There are some studies by Blue Cross/Blue Shield of Indiana and by Johnson & Johnson that do show some cost impact. I think maybe that would be an area of further evaluation to see whether there is something the Federal Government could do in this area and to assess whatever it might do to see the cost impact.

Mr. ACKERMAN. That's most welcome. Thank you.

Dr. Snook, let me thank you and your very distinguished panel. Mr. Myers would like to submit some questions to OPM and CRS and GAO for the record, as might other members of the subcommittee. So, without objection, we will forward them to you in the cases where we have them, if that would be okay.

Dr. SNOOK. We would be happy to oblige.

Mr. ACKERMAN. We look forward to working with you and with your team as we progress through this process. We thank you and all of your supporting staff. Thank you very much.

Dr. SNOOK. Thank you, Mr. Chairman.

[The response to written questions follows. Also included are overview materials submitted for the record.]

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July 28, 1989

TO : Committee on Post Office and Civil Service
Subcommittee on Compensation and Employee Benefits
Attention: Bob Levi

FROM : The Federal Employees Health Benefits Team
Congressional Research Service

SUBJECT : **Response to Written Committee Questions**

We are providing the following answers to Chairman Ackerman's and Representative Gilman's questions following the Committee's May 24, 1989 hearing on the Federal Employees Health Benefits program (FEHBP).

Chairman Ackerman:

QUESTION: Are FEHBP plans discouraged from adopting aggressive methods of cost containment, such as utilization review and case management?

ANSWER: There are several reasons why FEHBP plans might be viewed as discouraged from offering the more aggressive cost control approaches adopted by some health plan sponsors.

First, many fee-for-service (FFS) plan participants regard any interference in their access to health care providers as a restriction in their prerogative to seek health care as they determine desirable. Managing participants' access to the provider is one way in which Health Maintenance Organizations (HMOs) control costs, and this practice marks an important distinction between HMOs and FFS plans. Presumably, FEHBP enrollees that choose FFS plans rather than HMOs do so in part because they value the access to provider services FFS plans entail. Consequently, a FFS plan that adopted more restrictive controls on access might lose a measure of competitiveness with FFS plans that do not have such controls. One way to correct for this disincentive would be to require that all plans adopt similar controls at the same time.

Another reason that such controls might not be attractive is that they cost money to administer. Because FEHBP plans are "rated," that is, their

premiums reflect not only expected cost of claims but past gains or losses from previous years, the financial health of the FFS plans depends chiefly on the efficiency with which they administer benefit claims and is not affected by how well they hold down claims. Consequently, if aggressive cost controls were successful in reducing claims, the additional expense would actually reduce the plan sponsor's income.

Furthermore, because plans are not really at risk, nor do they profit from claims experience, it is an important task of the Office of Personnel Management (OPM) to make sure that plans are not charging excessive amounts for administration in an attempt to improve what "profits" they receive. Because the success of cost controls is very difficult to measure, it is also not easy to evaluate the efficacy of allowing additional administrative expenses to plans that claim to exercise such controls.

Representative Gilman:

1. **QUESTION**: How well do cost control measures, such as utilization review, work? Are savings achieved in the long run as well as the short run? What other type of cost control measures would be well suited for the FEHBP?

1. **ANSWER**: The cost of a health plan depends on two factors: (1) the quantity of services used by those covered by the health plan, and (2) the price the health plan reimburses for those services. Health plan cost containment measures attempt to control one or both of these utilization and payment factors. In addition, there are certain administrative features that health plans employ to help contain costs.

Many employers attempt to contain health plan costs through the basic design of the plan. Some examples include:

- excluding from coverage certain services (e.g., cosmetic surgery) or the services of certain health care providers (e.g., chiropractors);
- requiring enrollees to pay a portion of the cost of covered services (known as enrollee cost sharing, through deductibles, coinsurance, or copayments);
- providing incentives for enrollees to use services in less expensive settings, for example by requiring lower enrollee coinsurance amounts for outpatient surgery than for more expensive inpatient surgery;
- limiting the amount of provider charges that will be reimbursed (for example, through payments limits such as "reasonable and customary" limits or through "prospective payment" systems); and
- requiring enrollees to share in the premium cost.

"Managed care" is a term used to describe certain health plan features designed to limit or control enrollees' use of covered services. Managed care techniques often used by health plans include:

- hospital utilization review, where the health plan requires prior approval for nonemergency hospitalization and reviews the length of hospital stay and the plan of treatment;

- second surgical opinions, where enrollees must receive a second opinion for recommended nonemergency surgery;

- catastrophic case management, where very expensive cases are assigned a case manager to help remove impediments to hospital discharge (for example, by assisting in transfer to a skilled nursing facility or arranging for home health care).

Alternative health care financing or delivery systems such as HMOs and preferred provider organizations (PPOs) are also used to manage utilization and cost of health care plans. HMOs attempt to control unnecessary services and costs by "managing" the care provided through the HMO's health care providers. PPOs are arrangements where a health plan or employer contracts with health care providers who offer their services at reduced rates, which are made possible through many of the managed care techniques already described. The health plan includes financial incentives, such as lower cost-sharing amounts, to encourage enrollees to use these "preferred" providers.

Health promotion efforts such as coverage of routine exams, immunizations, and smoking cessation and substance abuse programs are sometimes incorporated to control health plan costs. Although the impact of health promotion programs on health status may be favorable, any resulting reduction in services and costs is difficult to quantify because the effects are usually long term

In addition, certain administrative efforts are used to control costs, such as claims review; coordination of benefits rules to determine payment when the enrollee is covered by more than one plan; and self insurance, where employers insure themselves by funding all claims costs rather than paying an insurer to do so.

Currently, FEHBP achieves some savings by encouraging participating insurers to select and apply cost control measures. At their own initiative, many insurers incorporate the cost control techniques mentioned above. All FEHBP plans have enrollee cost sharing, and Federal law requires enrollee premium contributions. Most plans limit their payments to providers. Several plans use managed care techniques, and many HMOs participate in the program.

FEHBP, however, does not require that all plans includes cost control features. The current approach is relatively passive compared to typical

private employer plans and probably does not achieve the level of savings that could be realized through aggressive implementation of cost control measures throughout the program. One approach could be for OPM to select and require cost control measures that monitor the results of these measures.

Suggestions for FEHBP cost containment reform have included greater enrollee cost sharing or premium sharing, reductions in benefits, increased use of managed care techniques, and changes in the way providers are paid by, for example, by using a hospital prospective payment system like Medicare's. In addition, self insurance has been suggested as a way to have greater control over FEHBP operations and to reduce certain administrative expenses. All of these approaches have the potential of reducing FEHBP costs, although enrollee premium sharing reduces only the Government's share of the costs.

2. **QUESTION**: Presently, what long term or extended care coverage is available under the FEHBP? Do any of the plans offer coverage of skilled nursing care while the patient is at home? What would be the costs of a proposal to reimburse Federal employees for lost wages or income should that employee decide to stay at home and take care of a sick dependent in lieu of hiring skilled nursing care?

2. **ANSWER**: In 1989, 16 of the FEHBP fee-for-service (e.g., non-HMO) plans cover home health care services and care in an extended care facility. Six plans cover only home health care as a hospital alternative, and two cover only care in an extended care facility. Six plans cover neither of these benefits. Plans vary substantially in their coverage requirements, such as limits on days of coverage, number of home visits, and maximum allowable charge per home visit. Coinsurance rates also differ, but most plans pay 85 percent or more.

In providing cost estimates for H.R. 770, the Family and Medical Leave Act of 1989 as reported by the Post Office and Civil Service Committee on April 27, 1989, the Congressional Budget Office indicated (in H.Rept. 101-28, Part 2, p. 21-22) that allowing Federal Government employees up to 18 weeks of leave without pay for the care of a sick dependent (among other events) "would not result in significant additional costs to the federal government." Neither the bill nor the CBO estimate address the costs of reimbursing Federal employees for the resulting lost wages or income.

TABLE 1. Baseline Cost of Current FEHBP Compared to Costs of a "Typical" Private Sector Plan, 1989[a] ($ in billions)

	Current FEHBP	"Typical" private sector
Total program cost	$11.60	$14.50
Enrollee share	$3.41	$1.85
Government share	$8.19	$12.65
Percent share of costs:		
Enrollee share	29.4%	12.8%
Government share	70.6%	87.2%
Effects on enrollees:		
Number of enrollees (millions)	4.01	4.46
Average premium	$850	$415

[a]Costs as if plans representing "typical" practices in private employment were adopted for a population representative of the population eligible for FEHBP. Because the "typical" private sector plan assumes 100 percent employer paid Self Only coverage, about 450,000 individuals would become covered who do not now enroll in FEHBP.

Source: FEHBP Model.

THE FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM AND POSSIBLE STRATEGIES FOR REFORM

CHAPTER 1. OVERVIEW

I. INTRODUCTION

As the Federal Employees Health Benefits program (FEHBP) nears the end of its third decade of operation, it is undergoing scrutiny because many believe that the program no longer effectively serves the interests of the Federal Government, or of its current and former employees and their dependents. The annual "open season," during which participants elect a plan for the following year, causes considerable anxiety for some people who sense the need to make an important decision about which they understand little. Many retirees believe that they are unfairly treated under the program, especially in light of recent changes to Medicare. Others affected by the program are concerned that premium increases are larger than necessary. Finally, some question whether the program's principal distinguishing characteristic, choice among many plans, has undermined the effectiveness of the program itself.

Findings of the Study

The following are the findings of the study:

- Choice among many plans in FEHBP gives workers and retirees an opportunity to elect plans that most closely match their expected need for medical services. Enrollees can also elect plans that require lower premiums.

- These selections are generally in the interest of the individual enrollee, but can be "adverse" to the collective interests of an insured group. To guard against adverse selection, many plans design benefits to appeal to lower-risk, and discourage higher-risk enrollees.

- Choice among plans, in conjunction with the method by which the Federal share of premiums is calculated, has resulted in concentrations in some plans of persons with similar risks. This phenomenon is called "risk segmentation."

- Risk segmentation has led to substantially different premiums for the benefits of some plans, relative to the premiums that would occur if the plans covered the entire FEHBP population. For instance, a measure of standard benefit value shows a range of 41 percent in the value of benefits in FEHBP plans, while the range in their total premiums is 246 percent.

- This disparity in benefit values allows some enrollees to gain advantages, the sum of which largely match disadvantages borne by others. Because the Government generally contributes a fixed amount toward each plan, premium differences from plan to plan due to risk segmentation affect costs primarily borne by enrollees.

- The evolution of benefit packages makes informed choice difficult. About 16 percent of enrollees are in plans that have "scheduled allowances" for provider payments that can make financial exposure difficult to recognize. About 34 percent are in plans in which total premiums exceed the standard value of benefits.

- The presence of choice among plans does not have a significant effect on total program costs. However, the formula for calculating the Federal share of FEHBP premiums interacts with choice in a way that causes the Government share to rise.

- Federal payments for health insurance for the average Federal employee are approximately $1,100 per year less than employer payments for health insurance of a typical private sector counterpart.

- In FEHBP, the average enrollee pays about 29 percent of the average cost of benefits. This average enrollee share of benefit costs represents about 34 percent of costs of active workers, about 38 percent of costs for annuitants covered by Medicare, and about 18 percent of costs of annuitants in FEHBP only.

- If the Government paid the same share of benefits for annuitants covered by Medicare as a group as it now pays on average for the program as a whole (71 percent), then their average premiums could be significantly lower.

- Many annuitants in FEHBP and also covered by Medicare, waste thousands of dollars of their own money by being in plans that require high premiums for benefits they cannot use.

- Nevertheless, on average, Federal annuitants covered by both Medicare and FEHBP have benefit payments from FEHBP that exceed their premium payments.

- Average increases in total program costs over the last 10 years are not unusual when compared to the experience of private sector health insurance plans.

- Money could be saved by adopting cost controls throughout the program and by eliminating unnecessary expenses not related to claims payments.

- More effective administration of the program is possible, and incorporating private sector innovations in health plan management could improve its operations.

- Major structural change to the program could solve perceived problems, but would not save money unless it was coupled with benefit reductions, more cost shifting to participants, or direct controls on providers.

This report examines FEHBP, compares it to the plans of other large employers, establishes a framework through which issues in the program can be understood, and displays methods by which the performance of the program and potential alternatives can be measured. The report begins with an overview of the program and the issues arising from consideration of reform.

A. History of FEHBP

Thirty years ago, Congress created a comprehensive health insurance program for Federal employees. FEHBP insures participating employees and retirees against financial hardship arising from costs of medical services. When enrollees or their covered dependents use medical services, part or all of the cost of those services can be paid by the program through one of its subsidiary plans. The cost of the program is shared between participants and the Government.

Before enactment of the program, Federal employees were generally responsible for securing their own health insurance. While some agencies offered group health insurance plans, there were no Federal contributions to those plans. A few employee organizations offered group health insurance to their members. Other employees purchased their own health insurance or were covered through the dependent provisions of their spouse's health insurance. Most had no health insurance.

After enactment of the original legislation in 1959, Blue Cross/Blue Shield (BC/BS) and the Aetna Life Insurance Company created Government-wide health insurance plans, each with two levels of benefits (high and low options). Employee organizations were authorized to establish plans for their members, and 13 organizations offered such plans. Also participating were 21 health maintenance organizations (HMOs), described in the law as "comprehensive medical plans."

B. Description of the Current Program

By 1989, the program has grown to include 30 different options that directly insure participants for covered services, and nearly 440 HMOs. Employee organizations sponsor 26 of the fee-for-service (FFS)[1] options. Each employee and retiree actually chooses from no more than 37 options, and no less than 21 options, the difference primarily determined by the number of HMOs available in the individual's local area.

There are 2.5 million employees, 1.5 million annuitants, and 5 million dependents in the program. About 16 percent of eligible employees elect not to be covered by the program, thus forfeiting their share of the Federal

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[1]In FEHBP, service or indemnity plans are both officially referred to as "fee-for-service." Elsewhere in the health insurance industry that term is often used to refer to a specific structure for paying providers, rather than to an insurance plan itself.

employer subsidy to FEHBP. Most of these people are covered through some other health insurance, often provided by the employer of a spouse. Certain temporary employees, and retirees not participating in the program during the 5 years before retirement are ineligible. About 450,000 employees, and about 500,000 annuitants do not participate in the program.

The program is administered by the Office of Personnel Management (OPM). Although OPM has some influence over the benefits in individual plans, each plan is relatively free to design a package of benefits to appeal to enrollees during the annual "open season." The plans estimate premiums based on their anticipated costs for the upcoming year. In 1989, the total cost of FEHBP will reach $11.6 billion, of which the Federal Government (including the U.S. Postal Service (USPS)) share will be about $8.2 billion, or about 71 percent of the program's total cost. Enrollees will pay a total of about $3.4 billion in their share of plan premiums.

The Government share of each plan's premium is the dollar amount equal to a percentage (60 percent) of the average cost of six plans (the Big Six), which are specified in law as: (1) the higher of two options offered by BC/BS and Aetna (High Options), and (2) the two employee organization plans and two HMOs with the largest enrollments. In 1989, the Federal share of total premiums averages 71 percent, because of the high premiums for the two High Option plans in category (1). The Federal share cannot exceed 75 percent of the premium for any plan. An exception to this rule applies to postal workers, whose collective bargaining agreements with the USPS provide an employer share for postal workers of 75 percent of the Big Six, up to a maximum of 93.75 percent for any plan. For 1989, the average USPS contribution is 87 percent of the total average premium. In each plan, enrollees are responsible for the share of the premium not paid by the Government or USPS contribution.

II. PROGRAM ISSUES

Most major issues arise from three distinguishing characteristics of the program.

The existence of choice. The program gives participants a choice among a wide variety of individual plans that are relatively free to compete for participants by offering benefits at competitive premiums. This array of choices has led to a very uneven distribution of benefits and burdens among program participants. Some enrollees are uncertain or confused about the comparative value of different coverage, and some choose plans with difficult to recognize financial exposure. This situation has raised three policy questions:

- Does choice serve a useful purpose in the program?
- Should FEHBP strive for more uniformity in benefits and a more equal distribution of participants' costs?

- Is it the Federal employer's responsibility to protect its employees and retirees from unwise choices?

The treatment of annuitants. Annuitants can participate in the program on the same basis as employees. In addition, many annuitants are also covered by Medicare. In the past, some annuitants have seen this overlap in coverage as a reduction in the value of their retirement compensation package. With the enactment of the Medicare Catastrophic Coverage Act of 1988 (P.L. 100-360), many Federal annuitants believe that they have been unfairly burdened with a tax to support additional coverage that they neither want nor need.

The presence of annuitants in the program has had significant effects on certain plans. Because they are generally an older group, annuitants use more services. A concentration of annuitants in a plan will skew that plan's costs relative to the "value" of the benefits, when those benefits are measured against a common program standard. However, when this population reaches age 65, Medicare becomes the primary payer, thereby moderating the cost effects for annuitants under 65.

The treatment of annuitants in FEHBP raises two policy questions:

- Are Federal annuitants treated fairly with respect to health insurance?

- What would be the effect on FEHBP and its participants if annuitants were treated separately?

The issue of costs. Compared to the health insurance provided by other large employers, FEHBP places a heavy burden on employees' pocketbooks. Yet, in an era of Federal budget concerns, pressure exists to reduce the Government costs for FEHBP, especially in light of the rapid growth in costs of medical services. Key issues are:

- Are the costs of FEHBP unreasonable to the Federal Government and program participants?

- How might program reforms affect FEHBP costs?

In the following sections, these issues are introduced. Further discussion may be found in subsequent chapters of the report.

A. Choice

Group insurance implies that choice does not occur, it being a principle of group insurance that the burdens are shared by all regardless of the costs incurred by each. Because FEHBP permits enrollees to choose among different plans, the total participant population is not insured as a single group, but insurance is deployed through specific plans, which insure that plan population separately.

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What do participants gain from this choice in plans?

Defenders suggest that this broad choice gives participants three principal advantages:

- Competition among plans results in a wide variety of benefit packages.
- Participants are able to select the plan best suited to their expected needs, thereby gaining the most from their premiums.
- Competition among plans leads to the most efficient provision of services to participants and lowers program costs.

Federal enrollees and retirees can choose between Self or Family coverage, between FFS plans and HMOs, among numerous examples of each, and between two "options" (High or Standard) within some plans. No other employees and retirees have the number of choices available to FEHBP participants. This wide variety of choice was apparently not planned at the time the program was created, but it evolved in the absence of any direct effort to prevent it. The program is a special marketplace, the governing forces of which are neither assertive Federal authority nor free market competition, but elements of both.

Federal employees bear a considerable portion of the premiums for coverage, and can claim that this payment warrants a choice among benefit packages. An employer granting choice in health insurance options appears to acknowledge that individual enrollee circumstances differ sufficiently, so that enrollees should have the right to consider their specific circumstances when selecting coverage. For instance, many individuals are eligible for coverage elsewhere as a spouse, and may choose a plan that supplements that additional coverage, at a premium less than more comprehensive coverage would require.

Choice in the private sector. Choice among plans under employer-based programs in the private sector is much more limited than under FEHBP. In the private sector, premiums for employees' health insurance are usually paid by the employer, who also usually pays most of the premiums for dependent coverage. An increasing number of employers insure benefits themselves, contracting for claims processing and upward limits on losses associated with specific cases ("stop-loss"). Choice among FFS plans is not offered because the employer establishes coverage agreements with a plan that sets premiums for the group as a whole. Insurers compete for employee groups, not individuals. Because employees in private firms generally do not bear the premium costs directly, they do not have as strong a claim that they should determine the plan in which they participate.

Private sector employees can often choose to participate in an HMO, but this choice yields broader coverage in return for the restrictions on the choice of provider that HMOs require. Some employers offer incentives for

employees to enter HMOs because these prepaid arrangements are thought more effective in restraining costs while providing comprehensive coverage.

Choice among elements of compensation. In recent years, many private sector employers have offered fringe benefit arrangements whereby employees are allowed to select from among different health insurance benefit packages. Employees choosing plans of lesser value are able to devote the cost difference to other fringe benefits, or to wages. These flexible benefit plans are explicit recognition that the costs of all fringe benefits are a part of total compensation.

Employees sometimes advocate these flexible benefit approaches because they allow more control over the structure of their compensation. Employers recognize that these plans provide them an opportunity to fix compensation costs directly, rather than have a substantial portion of those costs uncontrolled. Health insurance is a large item in an employer's compensation requirements. Costs of health insurance are tied to the rate of increase in health care costs, which is increasing at a rate faster than the rate of wages. These flexible plans are sometimes seen as ways to reduce the growth in the value of the total compensation package.

Why didn't competition work to create an "efficient" market in FEHBP?

Some observers compare FEHBP to a "marketplace" in which health insurance can be purchased by individuals from among competing plans. Yet, several conditions mitigate this marketplace analogy:

- Entry into the market is restricted.

In an ideal competitive market, suppliers can enter without restriction, offering products that could substitute for ones already available. In FEHBP, new FFS plans can be approved only through legislation. HMOs can enter by meeting OPM's regulatory standards, and the increase in the number of such plans is a challenge to the financial stability of the FFS plans. Because HMOs are sometimes more appealing to younger enrollees, they cause an upward pressure on the costs of competing FFS plans.

- Profits are limited and plans are insulated from the effects of their mistakes.

FFS plans are limited in the profits and fees they are permitted to earn. When plans underestimate the level of premiums for the benefit package they provide to the enrollees, they set premiums sufficient to recover that loss. When they overestimate, they reduce premiums to return the gains. Thus, two conditions of an ideal competitive market are not present: There is neither opportunity for significant gain nor substantial loss.

- Differences among plans are difficult to ascertain.

Plans are similar in many aspects. All cover the same basic services, and most use common terminology to describe their coverage. Yet, important differences exist in the interaction of various provisions, so that actual benefit expenses may vary from plan-to-plan for the same services. Adequate information about similarities and differences is not readily available or easily understood, making "comparison shopping" difficult.

- In the face of "adverse selection," even if the other conditions for a competitive market hold, insurers will have to offer plan choices that will not be "efficient" for all consumers.

When insurers do not have adequate information about the health risks of their potential subscribers, they face a situation in which those subscribers may know enough about their own conditions to select a health insurance plan based upon its expected payments. Private sector insurers respond to this potential for "adverse selection," segmenting their risks by offering comprehensive coverage at appropriate prices to attract high-risk customers, and less than comprehensive coverage at a lower price to attract healthier individuals. This results in less than desired coverage for low-risk individuals, and higher costs for high-risk individuals than would be the case if premiums for more comprehensive coverage could be offered without regard to adverse selection.

Because of the way FEHBP now operates, its plans have little incentive to be efficient, because their success depends not on their effectiveness as group medical insurance, but on attaining an adequate number of low-risk users. Indeed, a plan has virtually no incentive to distinguish its product in a way that would appeal to high-risk users.

Given these limitations on competition within FEHBP, it seems likely that the full advantages of open competition are not being realized. The most important manifestations of these limitations are: (1) a range of choices that, while significant, falls short of actual benefit variations available in the centrally designed programs of many other large employers; (2) product pricing that reflects the health status of a plan's customers, often more than the basic value of the plan's benefits; (3) a set of outcomes that favors the most knowledgeable enrollees; and (4) confusion for customers who want to price-shop but have difficulty in determining the real value differences among the plans.

In FEHBP, competition for market share is more important than competition for profits at the risk of loss.

The most important competition in FEHBP appears to be for "market share." Because there is no opportunity for entrepreneurial gains or losses, plans raise or lower their financial position on the basis of enrollments. Higher enrollments mean more overhead expenses for claims processing, plan management, and other expenses. HMOs, particularly those that own and operate their own facilities, are especially interested in the impact of enrollment on "economies of scale." Declines in enrollment mean less

revenues, which in turn can mean layoffs in plan staff, or other difficulties in meeting regular financial obligations.

Employee organizations generally view their health plans with pride, and large enrollments are important for prestige. Several organization plans have become established and enduring financial operations in their own right, with the usual organizational imperatives to survive at the level of operations attained. Furthermore, employee organizations that charge an annual fee for nonmembers to enroll in the health plan have an obvious incentive to increase enrollments, and understandable concern about their decline.

For HMOs, the changes in enrollments have a potential impact on overhead expenses, but there is an additional financial aspect to their rating structures. HMOs compete with other plans, both inside and outside of FEHBP in specific localities. HMOs are viable if the contracts they have with providers, permit the provision of all covered services to a specific group of employees insured for a specific per capita fee. HMOs are at risk for greater than anticipated costs of utilization for groups of employees covered as a result of contracts with employers in their service area.

What is "risk segmentation," and what are its effects on FEHBP plans?

Choice in FEHBP has led to "risk segmentation." Risk segmentation results when many individuals with similar expected demands for medical services congregate in the same plans.

For example, many participants have remained in certain plans from the beginning of the program. These people, now often retired, are older and more likely to have higher health care expenses. Because plan premiums are determined by estimating the claims likely to be paid for the group enrolled in the plan, this congregation of risks causes those plan premiums to rise. As premiums rise, participants who do not expect to experience high claims migrate to plans that have lower premiums, causing the original plan to have an even higher average utilization. This escalating incentive to escape a plan that has a rising average utilization is called a "risk spiral."

Several effects follow from this segmentation.

- The premiums in many plans are affected more by enrollee characteristics, especially age, than by the value of plan benefits.

The FEHB Team developed a methodology that allows the value of plan benefits to be compared as if they were offered to a population representative of the entire FEHBP population, referred to throughout this report as the standard Federal population (SFP). Some plans have benefit packages far less valuable than the premiums charged, while others are an especially good bargain when measured against this "actuarial" standard. The team found that the actuarial value of the nine plans with the largest enrollments vary by no more than 35 percent, but the total premium (Federal plus enrollee

share) for the highest cost plan is 246 percent greater than that of the lowest cost plan.

This effect of population variance on premiums has caused some plans to have tremendous swings in the value of benefits relative to premiums, with large shifts in enrollment as workers and retirees recognize that disparity. People moving from one plan to another experience uncertainties in their coverage. Others manage to avoid premiums they would have had to pay if all FEHBP enrollment were under any one plan.

- Plans have an incentive to limit benefits attractive to older participants, because they are required to raise premiums to levels sufficient to insure the covered population, plus recover past losses.

The most important factor in determining a plan's financial stability is the population it attracts. Younger, healthier participants are more "desirable" from a plan's standpoint. Because plans set premiums to recover past losses as well as insure the expected population, increasing average age causes increases in premiums for plans that have acquired an expensive mix of risks.

Thus, plans are discouraged from offering some benefits, and have the incentive to offer others. Some plans have adopted aggressive marketing tactics that seem intended to appeal to younger people. Plans also have little incentive to incorporate cost control mechanisms if plan administrators perceive them to result in participant dissatisfaction and migration to another plan.

- Annual open seasons have become complex and confusing, and adequately informed choice is generally not attained. Some participants select plans that have insurance "gaps."

Although most FEHBP plans are similar in important ways, many differences do exist between them, and some can be very important as well as poorly understood. The evolution of benefit packages has made them quite complex, and it is difficult for many, perhaps most Federal workers and retirees to make an informed, rational choice among plans. Agency personnel offices vary in the degree to which they are able to assist in the choice, and OPM cannot eliminate confusion by developing information adequate to the needs of all enrollees. Many have chosen unwisely to stay in plans in which the benefit package is far more costly than a similar package in another plan. Others are in plans that could leave them with thousands of dollars in unexpected medical bills, after all plan insurance has been provided.

B. Annuitants

As older people, annuitants on average use more medical services than active workers. Thus, FEHBP is an important element in the retirement rights earned through Federal employment. Most annuitants age 65 and over are also entitled to Medicare, which has prompted demands that benefits of the two programs be more coordinated. Recognition of this overlapping

coverage raises questions about the equitable treatment of the annuitant population.

How are annuitants treated under FEHBP and Medicare?

About 1.5 million annuitants are enrolled in FEHBP. Eligible annuitants have the same rights as workers (open seasons, dependent coverage, choice in plans, premiums), and each plan places retirees in the same risk pool with workers.

Upon reaching age 65, most Federal annuitants become eligible for Medicare Hospital Insurance (HI, Part A). At age 65, retirees are also eligible to enroll in Part B (as are all U.S. residents age 65 or older), which pays some or all of physicians' or other medical services. Beginning in 1989, persons eligible for Medicare also receive catastrophic coverage protection, financed from an increase in the Part B premium and a new supplemental premium (surtax) based on income tax liability.

Except for differences in the calculation of the supplemental premiums for catastrophic protection, Medicare treats FEHBP annuitants the same as other eligible persons. Because the new catastrophic coverage is financed primarily by the income tax surtax, the different tax treatment of social security old age benefits relative to public employee retirement benefits created pressure to exempt a portion of Federal benefits from the calculation of the liability for the catastrophic premium.

Because most medical services are covered by both Medicare and FEHBP, the programs coordinate their benefit payments to eliminate double payments. Medicare is the "primary payer" for annuitants with dual coverage, and thus pays for most hospital and/or physician services. Because OPM requires FEHBP plans to waive coinsurance and deductibles for annuitants covered by both programs, those retirees have virtually 100 percent coverage for hospital and doctor bills.

The new catastrophic coverage will fill gaps for annuitants in some FEHBP plans, but it will have little effect on total coverage for most retirees. Medicare will pay for more medical expenses than it did before, in effect shifting costs from one Federal program to another. The new law included a provision that reduces the annuitant's share of FEHBP premiums to reflect the amount FEHBP would save. In 1989, FEHBP premiums are reduced by $3.10 per month for annuitants also eligible for Medicare.

What results from annuitant participation in FEHBP?

There are two important findings that illustrate how annuitants and FEHBP plans interact:

- Although annuitants with Medicare reduce the costs of the plans in which they enroll, this effect is more than offset by the high costs associated with annuitants without Medicare.

- Many annuitants entitled to Medicare do not choose lower-cost FEHBP plans, even though it is clearly to their advantage to do so.

As a group, because annuitants are the most expensive enrollees to insure for medical services, they tend to increase the cost of health insurance plans. Probably because they have been in the program the longest, and have remained with certain plans with which they are most familiar, they have concentrated in certain plans. The costs of these plans have risen, and as they have, younger persons whose "loyalty" to a specific plan is less firm have left in search of better benefit value in another plan. This migration of younger workers increases the cost of their former plans even more.

Many annuitants with Medicare waste thousands of dollars every year in unnecessary premiums by remaining in these high-cost plans that provide a high degree of duplicative coverage. In addition, because many younger enrollees have left these options, their costs have increased because of the rising level of "risks" remaining. Thus, the effect of a concentration of annuitants in any plan is to initiate a contest in which those with the greatest understanding of the dynamic at work will be the first to go. Those that remain, often the oldest, or sickest, or least familiar with the operations of group insurance, are the ones who pay the most for FEHBP relative to benefits received.

Are annuitants treated fairly under FEHBP?

Annuitants not covered by Medicare clearly have a benefit in retirement of considerable value. Because they are more costly to insure than other groups, their premiums are lower under the current system than they would be if all annuitants were in a separate risk pool and were rated separately.

For annuitants covered by Medicare, the issue is substantially different. As costs of FEHBP coverage have risen, annuitants have complained that they are disadvantaged as a result of overlapping coverage and additive premiums. The advent of catastrophic coverage, with its accompanying taxes, has caused Federal annuitants to protest this dual coverage with vigor. Simply put, these Federal retirees assert that they have acquired no significant new benefits as a result of the passage of catastrophic coverage and that they are being assessed a burdensome tax, even if they reject Medicare coverage.

The FEHB Team has determined that the following circumstances govern a conclusion about the fairness with which annuitants covered by Medicare are treated under FEHBP.

- On the whole, Federal annuitants covered by Medicare receive benefits paid by FEHBP that exceed the value of the average premium paid by that group.

Medicare pays most of the costs for annuitants with double coverage, which clearly lowers the value to them of coverage under FEHBP. However, because annuitants generally have higher medical expenses, and FEHBP

coinsurance and deductibles are waived, FEHBP also pays benefits for these retirees that it does not pay for other program participants. Although the value of the Federal share of the contribution differs from plan to plan, that share does help support the cost of annuitants covered by Medicare.

After balancing the respective benefits and costs of combined coverage, the average FEHBP benefits received by annuitants also covered by Medicare exceeds the average premium paid by those participants. "Medigap" policies purchased individually from private sector vendors would not generally be a good purchase for most annuitants eligible for both FEHBP and Medicare, because the Federal contribution to help pay the cost of benefits would not be present. Thus, annuitants covered by Medicare, as a group can be said to get their "moneysworth" from participating in FEHBP.

- By and large, the private sector provides less health insurance coverage for retirees but usually at nominal cost to the retiree.

In the private sector, about 24 percent of employers do not provide medical coverage to retirees. Of those that do, 90 percent extend coverage past age 65. About half the time, the coverage was provided at no cost to the retiree; only 15 percent had to pay the full cost of coverage. Private sector annuitants whose employers provide them with broad coverage after age 65, also are critical of the new Medicare catastrophic coverage, asserting that the additional catastrophic tax gives them little or no additional coverage.

- Federal annuitants covered by FEHBP and Medicare, although treated differently, are treated with "relative fairness" compared to their private sector counterparts, under the surtax financing catastrophic coverage.

Federal retirees are allowed an adjustment in determining their relative placement within the distribution of the burden for financing the additional coverage. The catastrophic surtax is computed on the basis of income tax liability, and because social security old age benefits are at an advantage relative to some Federal retirement benefits in determining income tax liability, the law establishing the catastrophic protection contained an exemption for a portion of Civil Service Retirement System (CSRS) annuities before the surtax liability is computed. While further study could show that the amount of this exemption might need adjustment for certain categories of Federal annuitants, that does not suggest that Federal retirees covered for health insurance by both FEHBP and Medicare are treated unfairly by the application of the surtax itself.

The catastrophic legislation is predicated on the assumption that many individuals were without such coverage, and indeed data show that many elderly were exposed to the circumstances covered by the additional insurance. The supplemental premium tax to finance the coverage is intended to reflect the experience of Medicare beneficiaries, with the burden for the financing distributed progressively among the members of the entire Medicare population.

Some have suggested that the coverage should be financed on a broader population than those eligible for its protection. This claim rests on an assumption that catastrophic coverage is more of a social insurance benefit that should be financed with transfers from the general population.

- Federal annuitants covered by both FEHBP and Medicare pay a higher percentage of their benefit costs than do other participants in FEHBP.

Because Medicare pays most of the medical bills of retirees covered by both programs, such annuitants cost FEHBP less than other groups within the program. Nevertheless, those FEHBP annuitants pay premiums that are identical to those paid by other enrollees. Thus, these annuitants assert that they are unfairly subsidizing the premiums of other FEHBP participants.

In 1989, the average enrollee share of premiums is 29 percent. This average share represents 18 percent of the cost of benefits for annuitants not covered by Medicare, and rises to 38 percent for annuitants covered by Medicare. The average share for workers is 34 percent.

Thus, while these annuitants covered by Medicare, as a group, do receive benefits greater than the average value of their own premiums because of the Federal payments, they receive a much smaller than average share of the Federal Government payment to the program. If a systemwide medigap plan were created, an issue would arise as to the proper share of the plan's premiums to be borne by the Federal Government and enrolled retirees. If the average Federal share of costs for this group were increased to the same percentage as the current system average Federal payment, then their premiums could be, on average, 24 percent smaller than the system average.

There is no objective basis for determining the appropriate share of FEHBP premiums that should be paid by the Federal Government to Federal annuitants covered by both Medicare and FEHBP. The value of the Federal share to FEHBP is more heavily weighted toward younger retirees than active workers or retirees covered by both programs. Annuitants with Medicare who argue that they unfairly subsidize others, make an implicit claim that the Federal payment for their premiums should have the same average value as that paid for all others in FEHBP. Yet, the value of the Federal subsidy varies from plan to plan for all participants, as does the value of the subsidy each individual receives from the Government and/or exchanges with all other participants.

The right to participate in the program is earned by a Federal career, and employers have an obligation to determine the proper balance between adequate protection and equitable treatment for the workers it employs, but such a balance most clearly applies to the treatment of workers in service contemporary to each other. The proper share of total compensation distributed between workers and retirees is difficult to establish, given that the relative values of each can change significantly during the course of a person's career and subsequent retirement. In FEHBP, generational transfers

of program subsidies are passing phases rather than distinctions within an objective of equitable treatment. A high probability exists that a retiree will pass through all phases during a lifetime.

Could premiums for the annuitant population be determined separately from others in FEHBP?

It is sometimes suggested that Federal annuitants should be placed in a separate coverage group with separate premium ratings. Separating the categories of risk, and changing annuitants' different premiums would diminish the extent to which concentrations of retirees in certain plans drives up their costs and makes them less desirable for younger workers. On the other hand, the premium for the annuitant group would rise, and the claim that annuitants covered by Medicare are unfairly subsidizing others would be even stronger.

Sometimes when private sector employers provide health insurance to their retirees, they treat them as a separate risk group with corresponding separate premium rates. However, this treatment of retirees is not particularly relevant to FEHBP for two reasons.

First, on average, private sector plan sponsors are not faced with a large number of retirees so young that they are not eligible for Medicare for many years, as is common to FEHBP, even though the average age of retirement is fairly close in both private and Federal employment. Private sector retirees cluster their entry into retirement around the age of 62, when the old age portion of social security benefits first become payable. While average Federal retirement is also around age 62, Federal retirees often retire as early as age 55. Thus, compared to FEHBP, the private sector employer-based health insurance plan bears the full cost of retiree health insurance for only a few years for most enrollees, before Medicare begins to pay most retiree health care costs.

Second, in the private sector, the premium responsibility for health insurance is borne almost exclusively by the employer, with the retiree responsible for a portion of dependent coverage. Thus, a separate risk group makes little difference to the total obligation of the employer for health insurance, provided the employer is committed to providing retiree coverage. However, the separate risk group has made the high cost of retiree health insurance evident and is making such coverage an issue in private sector employee benefit relations. This issue can be expected to intensify, as pressure mounts for firms to account for these obligations as liabilities against the firms's assets.

Could annuitants over age 65 ineligible for Medicare be brought into that program?

If the Federal Government were to purchase Medicare for annuitants otherwise ineligible for its benefits, FEHBP costs would be lower, as Medicare would become the primary payer for benefits now paid from FEHBP. These

annuitants would receive greater coverage than they do now, as their FEHBP deductibles and coinsurance would be waived. To the extent all annuitants over age 65 would be treated uniformly, there would be less confusion by annuitants in choosing health plans, and administration would be simplified.

However, cost savings to FEHBP would be mitigated because most nonmedicare-covered annuitants are too young to be enrolled in Medicare. Moreover, these savings may be completely offset by the cost of purchasing the Medicare coverage, and by the resulting rise in Medicare outlays. Savings realized may be only to the extent Medicare cost containment efforts prove more effective than those in FEHBP.

Could a separate option for annuitants covered by Medicare be created?

Separate options for annuitants covered by Medicare could be created that would reflect that group's experience and whose benefits would be designed to supplement rather than overlap Medicare's coverage. New options that take into consideration the benefits paid by Medicare for these annuitants might be better designed than any plan now available to them because it would be intended for a defined group. Although the structure through which coverage is provided structure would be more clearly identifiable than the current overlapping FEHBP approach of FEHBP and Medicare, there is no necessity for the total cost of benefits from the combination of Medicare and a special supplement for Federal annuitants to differ from what is now received.

If the total value of benefits from a new program were to include the total value in benefits now received by the group under various FEHBP plans, then the total cost for both programs would be the same as current FEHBP costs are now. The more difficult policy issue to resolve would be the proper share of the premium that would be paid by the Federal Government and by annuitants. If annuitants in the new option paid less as a group than they do now, either Federal costs would rise, or the cost would have to be redistributed to other FEHBP enrollees through lower benefits or higher premiums.

What is an annuitant's right with respect to group health insurance?

It is sometimes argued that Federal employees "subsidize" the health care costs of Federal retirees, because the costs of the latter group are higher, thereby increasing costs paid by the former. However, the cost to FEHBP of annuitants covered by Medicare are actually lower than those of the average worker. Thus, some annuitants covered by Medicare argue that they subsidize everyone else because they continue to pay full FEHBP premiums after their benefits are largely paid from another program.

Federal annuitants participate in FEHBP only if they were first Federal employees. To the extent that these retirees earn the right to participate in FEHBP as part of their compensation, that right cannot be fairly challenged

on the grounds that their participation causes difficulties for the program. While that right could be challenged directly, no argument has been advanced to suggest that it should be. Proposals to solve problems that retiree participation causes for FEHBP, its plans, and other participants, should be predicated on their effectiveness as solutions for all parties, rather than on the extent to which they correct program difficulties at the expense of annuitants.

Nor can it be argued that subsidization of one group by another is necessarily grounds for adjusting the program's design. Group health insurance presumes substantial "cross-subsidies," and sorting out the relative weight of the subsidy each possible category of participant carries is contrary to that philosophy. Retirees without Medicare are subsidized by both workers and retirees covered by Medicare, and the last group subsidizes both of the other groups but to different degrees. In the life cycle, a given person normally moves between groups that provide subsidies to ones that receives them.

To speak of these subsidies is to speak of groups and not individuals. Actual enrollee premiums are paid by individuals. To the extent that some individuals in FEHBP subsidize others, then the greatest subsidy "disadvantage" accrues to the individual fortunate enough never to have the need to use the benefits paid by those premiums.

C. Costs

In recent years, much attention has been paid to the growing costs of FEHBP. At lower income levels, pay and annuity adjustments usually given each year to reflect changes in the cost of living have largely been consumed by increases in health insurance premiums. Because of concern about the Federal budget deficit, the Administration has proposed a change in the way the Federal share of the premium is calculated which would shift more of the cost of the program to participants. Others suggest that reform of the program could save money as well as improve the program's effectiveness. This section examines FEHBP costs, what affects their magnitude and growth, and how costs might be affected by program reforms.

Factors affecting group health insurance costs.

A variety of factors affect FEHBP costs:

Eligible population. Federal employees, retirees, and their eligible dependents constitute the population covered by FEHBP. Not only is the number of persons participating an important factor affecting costs, but so too is their use of health care services. There are a number of demographic and other characteristics that are used as surrogates for utilization: age, sex, family size, region of the country, have an important bearing on program costs.

Use of medical services. The health status of the population varies considerably, and so then does the amount of services used by that population.

To some degree, use of services may be accounted for by the demographic profile of the population, but not entirely. Other factors that affect a person's decision to seek treatment are also important, such as knowledge about health care, resources to pay for treatments, and the habits and preferences of health providers ("practice patterns"). Thus, as an intended effect, insurance encourages the use of services by providing a means for their payment, which then must be balanced against the probability that unnecessary use of services will also occur.

Plan benefit provisions. FEHBP plans vary in the services they cover and in the extent to which they pay the costs of services they cover. Plans may limit payments to charges they deem "reasonable and customary" in the locale in which the service is performed, or make payments according to a fixed schedule. Plans also vary in the interaction between deductibles, coinsurance, patient copayments, and maximum out-of-pocket limits.

Overhead and administration. In addition to the cost of paying claims for services, plans have costs for processing claims, maintaining reserves, paying premium taxes, and accounting for other overhead expenses. FEHBP plans also charge a small amount as payment for a presumed level of risk in FEHBP plan operations ("risk charge" or "profit").

The cost of a group health insurance plan is derived from several components. Ultimately, the costs of a group health insurance plan include the claims filed; less coinsurance, deductibles, copayments, and charges in excess of payment limits deemed reasonable by the carrier; plus expenses for administering the plan; and any required reserves or other expenses. The premium is this total amount divided by the number of enrollees in the plan.

By far the largest share of plan premiums is devoted to the payments made for the services performed. Thus, significant impact on costs is achieved only if changes are made in the amount of covered services used, or in the payments made for the charges attached to the services provided.

Are FEHBP costs too high?

In order to evaluate the cost of FEHBP, it is helpful to compare its costs against some alternative.

- Although in recent years FEHBP premiums have increased dramatically, the rate of increase in average FEHBP premiums through the 1980s is similar to the growth in premiums in private sector plans.

During each of the last 3 years, FEHBP premiums have increased on average by 20 percent. Over the last 9 years, FEHBP premiums have grown by an average of 12 percent annually. However, special circumstances held down premiums, in 2 years--1982 and 1986. Despite year-to-year differences, the cumulative increase in FEHBP premiums would be nearly the same as

that experienced by private sector firms were it not for the substantial cost shifting to participants in 1982.

In 1982 OPM instructed FFS plans to reduce their benefit costs by 13 percent. This reduction was primarily accomplished by the introduction into these plans of various copayments and deductibles. This implementation of cost shifting reduced by half what would have been an average increase in 1982 in FEHBP premiums of 35 percent. In 1986, concern about growing reserves caused plans to draw them down. This resulted in a $1 billion rebate plus an average reduction in the 1986 premiums of about 11 percent.

Other factors also affect the growth in FEHBP premiums. About one-half of the increase in FEHBP premiums has been caused by increases in medical care services costs. About one-fourth has been caused by a net increase (400,000) in the number of annuitants in the program which, because of the increase in average age, also caused average utilization to increase. Some of the remaining one-fourth of the increase is attributable to the ebb and flow of various cost recovery and reserve building that occurs each year. Finally, utilization patterns for health services change with both the introduction of new forms of medical technology and changes in opinions about the effectiveness of specific treatments.

- The typical FEHBP plan is less generous than the typical private sector plan, when measured against a standard Federal population.

The team computed the pure premium[2] cost of a typical FEHBP and private sector plan, as if those plans were applied to a population representative of FEHBP participants. The difference in the cost of the two plans is about 15 percent, primarily caused by the more generous dental benefits, mental health coverage, and generally lower enrollee cost-sharing requirements in private sector plans.

Another way to compare the value of FEHBP coverage is to treat the Federal payment to FEHBP as a form of compensation. The average annual Government payment for employee health insurance is $2,861. The comparable private sector employee earning $30,000 (the average Federal salary) receives an employer health benefit worth $3,960 (a difference that equates to from 3 to 7 percent of Federal pay). After weighting for differences in retiree coverage, the private sector value of employer-paid health coverage exceeds the FEHBP payment by 38 percent, an advantage that increases for workers at higher salaries in the private sector.

Most of this difference is accounted for by the different methods for meeting the total plan premium. In general, the practice in the private sector is for the employer to pay 100 percent of the premium for the employee, and

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[2]Pure premiums are determined by dividing the total cost of benefits by the number of persons in the covered group. Excluded are amounts for reserves, premium taxes, administration and overhead.

about 75 percent of the premium for any dependents. The employer can deduct these payments from the firm's taxable income as a business expense. If private sector employees were to pay these premiums, they would have to use after-tax income, as Federal employees must in paying their share of FEHBP premiums. Thus, in the private sector, there is an incentive for workers to accept lower wages in return for employer-paid health insurance, if the gross value of the foregone wages is roughly equal to the employer share of health insurance costs.

The premiums FEHBP enrollees pay tend to vary by their age and income, as a result of the types of plans to which they tend to gravitate. Among active workers (including postal workers), the average premium of the plans in which workers are enrolled tends to increase with age, even after controlling for workers' pay levels. Also, within each age group, higher-paid Federal workers, on average, choose plans with premiums that are higher than the plans that lower-paid Federal workers choose. However, FEHBP premiums, as a percent of enrollee pay, are higher on average for lower-paid Federal workers, in spite of the fact that lower-paid workers tend to be enrolled in lower-cost plans.

Would adopting cost control measures save money?

As health care costs have risen, many employers have sought ways to restrain that growth. Some savings are achieved by developing more efficient administrative procedures and reducing or avoiding costs associated with other aspects of providing insurance. Generally, however, reducing health insurance costs requires changing either the amount of services that are provided to the group or the payments that are made for services.

Employers have introduced methods by which the participants are made to share in the costs incurred beyond the actual employee premiums. Several strategies for achieving these ends have been incorporated by some FEHBP plans. Some of these cost-saving efforts have been undertaken by the plans themselves, while others have been required by OPM in an effort to reduce Federal costs.

- A package of plan-based cost control measures is generally thought to save money in private sector plans.

Private sector vendors of health insurance plans do give credit toward the computation of a premium if the plan has incorporated a common package of cost control measures, although some analysts doubt that they can reduce costs substantially. OPM has encouraged FEHBP plans to adopt these techniques. While a few plans have incorporated some of these approaches, adoption of utilization controls (case management, preadmission certification, second surgical opinions, outpatient surgery, alternative services, etc.) is not uniform throughout the program because of its possible dampening effect on plan enrollment.

- Costs could be saved on certain administrative expenses, although more efficient administration could also increase other costs.

Certain fees required for the operation of FEHBP do not directly bear upon the relationship between medical services and costs. For instance, plans are required to include in their estimated premiums, amounts for reserve funds. These reserve levels are theoretically intended to guarantee the security of the insurance rights purchased through each plan. Yet, because the Federal Government has assumed the responsibility for assuring the continuation of this program, actual reserve levels do not increase the security of the insurance.

Furthermore, because FFS plans must set premiums to recover their losses, their actual financial risk is limited to the possibility that the program would terminate. Thus, risk charge amounts included in the premium could be eliminated if the Government explicitly accepted the risk by defining FEHBP as self-insured.

Finally, the extent to which each plan allocates a portion of revenues for claims processing varies from 4 percent to nearly 13 percent. Certainly, aggressive administrative efforts could return dividends if the additional effort were applied to claims review or to attain greater efficiency, but savings from these additional administrative efforts would be hard to quantify. GAO is currently examining FEHBP to determine ways in which better administration of the program could save money.

- The consumer power of the FEHBP population could be unified.

Group health plans have frequently shown savings in plan costs by contracting with medical service providers. In return for encouraging participants to use the favored providers, those providers grant discounts to the plan. Indeed, many systems of health insurance (PPOs, HMOs) depend on one variation or another of these arrangements in order to compete with plans that give participants a wider choice in the selection of providers. Such plans could return these savings to the insurance purchaser in lower premiums or more extensive coverage.

The Federal Government is the largest purchaser of employee health insurance in the United States. It is conceivable that discounts and other advantages could flow to FEHBP if the program were to negotiate fees as a group. In the present arrangement, Federal workers and retirees are not always able to exercise sufficient consumer power to generate discounts.

- The most aggressive form of control would directly affect provider services and/or payments.

Directly limiting the payments that the plan would make to hospitals, physicians, and other health service providers is advocated by some analysts of health care cost containment efforts. Medicare has implemented a "prospective payment" system that sets payments for inpatient hospital services

based on the diagnosis of the patient. Medicare has also frozen fees to physicians for a limited time period, and directly reduced the payment levels of some procedures designated as overpriced.

The most direct method of controlling costs involves limiting the volume and intensity of services. Some concern exists because such an approach entails the exercise of medical judgments by persons other than the provider. Many plans already incorporate "gatekeeper" approaches that are intended to diminish the provision of unnecessary services. Further effort to restrict services requires the development of guidelines, against which the appropriateness of particular services could be determined.

Adopting these approaches would require the development of an extensive data base, along with methodologies for evaluating the appropriateness of particular services in defined situations. Whether this expertise will emerge with sufficient reliability to be effective as cost containment, while at the same time maintaining an acceptable level of quality in the provision of medical services, is as yet uncertain.

Would reform of FEHBP structure save money?

Some critics of FEHBP advocate major structural reform as a way to save money, expecting to find in the present design some characteristic that exhibits unreasonable costs.

For instance, some have suggested that the existence of choice in FEHBP adds to program costs, as participants move from plan to plan in an attempt to match benefits with expected needs. While some migration in search of particular benefits does exist, the team found that its impact on overall program costs is insignificant. Most migration is in pursuit of lower premiums. Some of these "premium shoppers" choose plans in which the actuarial value of benefits is less than that of the average FEHBP benefit package. Thus, rather than cost money, choice actually leads some enrollees to elect lower-cost plans that expose them to larger financial risks.

Choice does raise the amount of FEHBP premiums paid by the Federal Government because of the operation of the Big Six formula (60 percent of the unweighted average of the six plans). Because two of the plans in the Big Six are affected adversely by risk segmentation, the standard Federal contribution to FEHBP plans increases when premiums for those two plans rise. The formula could be modified to account for this effect, but reducing the Federal cost without changing the program simply shifts costs to the participants.

Program reform will not save money unless coupled with benefit reductions, higher costs for at least some participants, or direct program limitations on the discretion with which health care providers prescribe services and receive insurance payments. For instance, consider the following factors:

- About 16 percent of the employees eligible to participate waive health coverage and forfeits the Federal contribution to the program. If a reformed program became more attractive, some of these nonparticipants would elect coverage.

- About 500,000 annuitants do not participate. Some consideration might be given to granting an opportunity for these annuitants to join the reformed program.

- Some potential FEHBP enrollees are not covered by any health insurance. Congress has also been interested in extending health coverage to uninsured Americans. That interest could translate into pressure to include these noncovered Federal workers and retirees in any reform effort.

- Pressures for reform could lead to improvements in the treatment of some program participants. Unless the price for improvements were met by a corresponding decrease in the value of coverage for others, then such improvements would have net costs.

III. STRATEGIES FOR REFORM

In chapter 3, a methodology for analyzing alternative means of reforming FEHBP is demonstrated. That analytic framework examines FEHBP issues in the context of general strategies, with variations in the specifics of those strategies compared. The strategies are not recommendations, or proposals. They are illustrations of the methodology and a way for FEHBP issues to be examined in a context of perceived problems and possible solutions.

Each strategy is made up of six components, and each component includes several variations. Three general strategies are examined:

- A package of changes to the current program.

- A new program, restructured to provide multiple choices within a controlled environment.

- A new program, structured to resemble the plans typical of large firms.

Strategy 1: Changes to the Current Program

Strategy 1 presumes that the current program needs adjustments, but that reforms should retain the essential characteristic of participant choice from among existing plans.

Benefit design. Confusion among alternative packages could be eliminated if more control were exercised over benefit designs. Minimum standards in benefits could be established to eliminate gaps in coverage. A core package could be adopted that specifies benefits which must be offered, supplemented

by different packages of additional coverage. The most certain control over benefit packages would entail specifying all benefits that could be offered.

Cost controls. OPM currently encourages plans to include cost control measures, but has not established common plan requirements. Cost controls could be required of each plan, or minimum standards for cost controls could be set. Data collection could be standardized and expertise developed to monitor effectiveness of these controls. The most aggressive form of cost control would reduce the volume of services or payments by placing controls on the providers.

Enrollee choices. Permitting enrollees to choose among a large number of plans is thought to lead to FEHBP's most difficult problems. Restricting those choices, either by reducing the number of plans and/or by limiting employee organization plans to members, could diminish choice-related problems. The tendency for risks to congregate in particular plans would diminish, especially if the eliminated plans were those in which similar risks have congregated.

Premium sharing. The current formula for determining the dollar amount paid by the Federal Government for each plan's premium, in conjunction with risk segmentation, causes the Federal percentage of program costs to rise. However, because of risk segmentation, that increase is not shared evenly among the enrollees. This issue can be addressed by a combination of changes. First, the Federal payment percentage could be frozen at its current level, or a "weighted average" formula could be adopted that would neutralize the effect that certain plans now have on the formula determining the Federal share. In addition, the Federal payment for each plan could be designed to reflect risk variations within plans, or enrollee premiums could be set by linking them to the value of different benefit packages measured against a common standard.

Treatment of annuitants. Many retirees are spending more than they are likely to "need" for adequate health insurance. Some retirees believe they are unfairly treated because of the overlaps in coverage between FEHBP and Medicare. Separate plans specifically tailored to the circumstances of retirees covered by Medicare could be designed at different levels of generosity. Retirees age 65 and over but not eligible for Medicare could be brought into that program.

Financing. Because plans are able to recover prior year losses by increasing premiums, the Federal Government is effectively self-insuring FEHBP. Nevertheless, the method by which reserves are developed has an effect on premiums. FEHBP could more explicitly self insure, and the practice of requiring each plan to include a specific insurance component within its annual premium rate could be eliminated. The Federal Government could also eliminate other charges included in the premium rate, such as State government premium taxes.

Strategy 2: A New Multiple Choice Plan

If it were concluded that the current program structure should be changed, then a new program could be designed that retains some aspects of the current program. This new program could retain some variation in plans, but operations could be more directly controlled.

Benefit design. The number of different benefit packages could be strictly limited. As in *strategy 1*, the designs could be restricted by setting minimum standards, requiring a core package with alternative supplements, or specifying all benefits that could be offered.

Cost controls. The issues in cost controls in *strategy 2* are not significantly different from those in *strategy 1*. The greater central program authority implied for *strategy 2* might make it easier to establish more direct reviews over the payments and provision of services in HMOs.

Enrollee choice. For purposes of illustration, *strategy 2* is analyzed as if the choice among plans were limited to one core benefit package for the FFS plans and three different levels of supplements. The cost projections in chapter 3 assume that the Federal Government would pay 100 percent for Self Only and 75 percent for Family coverage. The supplements could include dental and prescription drug coverage, and additional mental health benefits. The number of HMOs could be limited or expanded.

Premium sharing. Strategy 2 implies direct control over the conditions under which multiple choice among plans occurs. The amounts paid by participants could reflect the value of benefit package differences (measured against a common standard), or the Federal payment for each plan's premium could reflect the differing risks among the populations enrolled in each plan.

Treatment of annuitants. As in *strategy 1*, the principal alternative treatment of annuitants would be to design a package especially for the population covered by Medicare. *Strategy 2* also requires determining the level of coverage and Federal subsidy in these separate retiree options.

Financing. Inherent in the design of *strategy 2* is a self-insured FEHBP. State premium taxes could then be excluded from the premium cost.

Strategy 3: A Typical Private Sector Approach

In most firms in the private sector, employees participate in one FFS plan or they can choose to enroll in a selected HMO. The employer pays most of the premium costs. Private sector plans differ considerably in design and generosity of benefit packages, but on average they are more generous than the typical FEHBP plan.

Benefit design. As is typical in the private sector, only one FFS plan is offered. For purposes of analysis, the design of this plan follows typical private sector practice.

Cost controls. The design of the plan would entail specifying the cost controls required. The design and operation of participating HMOs could be aggressively administered. The single plan approach could facilitate direct controls on provider services and payments, and a unified FEHBP population could be a potent consumer force.

Enrollee choice. In typical private sector plans, choices among HMOs are limited. Some employers make an effort to centrally coordinate HMOs participating from different regions.

Premium sharing. Projected costs for *strategy 3* assume full Federal employer payment for employees and 75 percent payment for dependents, the typical private sector practice. The Federal contribution to HMOs could be equal to the dollar amount that would be paid to the FFS plan, with regional adjustments possible.

Treatment of annuitants. As was mentioned in previous examples, the principal treatment of annuitants involves creating a separate plan for those retirees also covered by Medicare. The Federal contribution to that separate plan could be determined on the same basis as the Federal share of the basic FFS plan or an alternative level of premium sharing could be established.

Financing. This strategy assumes that the Federal Government, like many large employers, would self insure the program. Reserves would not be necessary, although Congress could devise a method to assure the payment of claims independent of the annual appropriations process.

Mr. ACKERMAN. The final panel today is Mr. Bernard L. Ungar, Director, Division on Human Resource Management of the General Accounting Office. Welcome, Mr. Ungar. Please introduce your colleagues.

STATEMENT OF BERNARD L. UNGAR, DIRECTOR, FEDERAL HUMAN RESOURCE MANAGEMENT ISSUES, GENERAL GOVERNMENT DIVISION, U.S. GENERAL ACCOUNTING OFFICE; ACCOMPANIED BY MARJORIE HROUDA, ASSIGNMENT MANAGER, AND THOMAS EICKMEYER, ASSISTANT DIRECTOR

Mr. UNGAR. Thank you, Mr. Chairman.

On my right is Marjorie Hrouda, who is our assignment manager on our current effort to look at the administrative costs and fraud and abuse in the Federal Employees Health Benefits Program. On my left is Tom Eickmeyer, who is our Assistant Director responsible for our work that we do government-wide in the pay and compensation area in GAO.

We are pleased to be here this afternoon. We have been in the process of looking at a fairly limited aspect of the program, the administrative aspect of it. We are currently still in the process of making our assessment, so what we would like to do this afternoon is to give you an overview of some of the preliminary observations we have made.

Basically, what we have found so far is that there seems to have been a very limited OPM oversight role with regard to controlling and containing the administrative costs, as well as preventing and detecting fraud and abuse in the program.

First with respect to administrative costs, as the chart over to the right depicts, you can see there has been a significant increase. The second line from the top indicates administrative costs in the program and shows that over the last several years they have gone up about 75 percent. The top line on the chart shows the profit, the service charges of the plans, has gone up at even a greater rate during the last several years. The third line is the benefit level, and the bottom two lines show the cost of living and the employment cost index.

This basically says there is a large, unexplained reason for the increase in administrative costs not due to increases in the number of enrollees. It is not due to the cost of wages, the cost of living. It's a little bit unclear right now what all the factors are. We're in the process of looking at that.

Now, it is clear, though, or at least it would appear to be clear, that the controls over the growth of the administrative costs haven't been very effective. So far, we see that there seems to be little incentive in the program for the folks who are participating in it, the carriers, to control costs. They're reimbursed on a cost basis. OPM negotiates the ceiling with them. However, in a number of cases, the ceiling is twice what they have actually spent. So from that perspective, there hasn't been a great deal of incentive.

Also, although OPM does have some of the carriers do internal audits of administrative costs, we understand that generally these

internal audits do not cover the administrative cost of the program. They primarily look at eligibility and benefits paid.

In terms of the service charge, OPM has recognized in recent years a significant growth and a couple of years ago did start to institute some controls over the service charges and that has started to come down. It also has recently started to deal with some of the plans on containing administrative costs and has negotiated an agreement with, I guess, the largest plan. It looks like, if that type of control or incentive had been in effect over the last several years, the growth in administrative costs would have been substantially reduced from what it turned out to be.

In the area of fraud and abuse, we noted that over the last several years there have been six plans that have been identified as being involved in fraudulent or abusive activities. These include embezzlement, misuse of funds, and the charging to the Government for Federal income taxes, which is a nonallowable expense. Again, we note that OPM's controls over fraud and abuse seem to have been fairly limited and it hasn't really seemed to have taken a very proactive stance with respect to preventing and detecting fraud and abuse in the program.

Basically, it hasn't imposed stringent controls on the carriers. It has had a very, very limited audit effort. In fact, it looks like the audit cycle, from OPM's perspective, is about every three to ten years, over which it gets to audit some of the plans. For example, Aetna hasn't been audited for seven years. Aetna is a situation where they had been charging the Federal Government for that period of time for Federal income taxes.

Finally, as OPM indicated, the Financial Integrity Act was passed to basically make agencies and managers of programs more accountable for imposing management controls over their operations. OPM has not viewed the program as covering the FEHB program as it relates to the plan carriers. We strongly disagree with OPM. The Financial Integrity Act basically applies to Federal agencies. It requires the managers to set internal control objectives and institute adequate controls to make sure that assets are safeguarded and funds are properly expended and accounted for.

While we do agree with OPM that it doesn't directly apply to the carriers, certainly it holds that OPM managers are responsible for assessing the vulnerability of their programs, including the health benefit program, identifying those areas which are highly vulnerable, looking at the controls and making sure that the management controls are adequate. It just hasn't done that. In fact, it hasn't done that up until now. It seems to be taking the position that it doesn't have to. We hope to be working with OPM over the next several weeks to address that issue.

That sort of concludes my summary. We would be happy to answer any questions that you might have.

[The statement of Bernard L. Ungar follows. Also included is his response to written questions.]

United States General Accounting Office

Statement of
Bernard L. Ungar, Director
Federal Human Resource Management Issues
General Government Division

I am pleased to participate today in this hearing on the Federal Employees Health Benefits Program. The program is a major component of the government's compensation package and, as such, is an important factor in attracting and retaining a quality workforce. At the Subcommittee's request, we have been reviewing certain aspects of the program, including administrative cost trends, controls to prevent fraud and abuse, and oversight by the Office of Personnel Management (OPM). While we have much work yet to do, I would like to present our preliminary findings in these areas.

About 8 million federal employees, annuitants, and their dependents receive health benefits from the program, which in 1989 is estimated to cost $11.6 billion in premiums. The government will pay $8.2 billion, or 71 percent of this cost, with enrollees contributing the remainder. Health benefits are provided through 42 experience-rated plans which base their premiums on past claims experience and 333 community-rated plans, primarily health maintenance organizations (HMOs). Experience-rated plans account for about 90 percent of all program expenditures and are the focus of our work.

ADMINISTRATIVE COSTS

The cost data that I will discuss were obtained from financial reports for 1982 through 1987 filed with OPM by experience-rated plans. The reports are subject to adjustment and to audit by OPM. Reports for 1988 were not filed in time for our review. Administrative expenses incurred by experience-rated plans are reimbursed subject to an OPM-imposed ceiling. Premium taxes imposed by states and other governmental entities on plan insurance underwriters are also reimbursed.

In 1987, the experience-rated plans spent about $7 billion, or 89 percent of all program funds. About 90 percent of this amount was paid to enrollees or their health care providers for benefit claims. The remainder was for administrative expenses ($448 million), premium taxes ($44 million), plus service charges ($42 million), which are the plans' profits. While small in relation to benefit payments, these three items have escalated rapidly and, at $534 million, are a significant program cost.

As the graph we brought with us today shows (see attachment), the plans' administrative expenses increased by 75 percent over the 5-year period, or about 1.4 times the increase in benefits paid. The magnitude of this increase cannot be attributed to growth in enrollment, which increased by less than 2 percent. However, as the graph shows, these costs would have been affected to some

extent by wage and price inflation as the Employment Cost Index[1] went up by 21 percent and the Consumer Price Index grew by 18 percent. We will be seeking further explanations for this increase as part of our ongoing review.

The graph also shows that service charges increased at a much faster rate than administrative expenses through 1984. Although they have since leveled off, the plans' profits increased by 77 percent over the 5-year period.

OPM used administrative expense ceilings annually negotiated with the plans as its primary cost control measure but the ceilings have not been an effective control. Seldom during the six years we reviewed did the larger plans' expenses reach their ceilings and, in several instances, their ceilings were set at twice the amounts actually spent. OPM also audits the plans periodically to assure that expenses charged to the program were proper.

OPM is now in the process of changing the way administrative expense ceilings are set. For 1988, the ceiling negotiated with the program's largest plan established a base-year expense level to be adjusted in subsequent years for changes in enrollment and inflation. OPM is also negotiating administrative expense ceilings based on this formula with other plans. As an

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[1]The Employment Cost Index is a principal federal economic indicator that measures changes in compensation levels for all occupations in the non-farm economy.

illustration of the significance of this change, if the ceilings had been based on the new formula, administrative expenses for the period would have increased less than 25 percent and would have been $132 million less in 1987. This amounts to about two percent of plan costs and premiums could have been reduced accordingly. As the Subcommittee requested, we will be further exploring the causes for the rapid increases in administrative expenses and service charges and evaluating the reasonableness of these costs by gathering data from large state and private sector plans.

Additionally, in 1987, 22 of the experience-rated plans charged the program $44 million for premium taxes imposed on the plans' insurance underwriters by all 50 states and other governmental entities. Some plans pay no premium taxes because they are self insured and do not use insurance underwriters. In 1980, Congress exempted the federal employees life insurance program premiums from similar premium-based taxes because it considered the program to be self insured. Because any plan losses in one year are recovered through higher premiums in the following years, the health benefits program is operated as if it were self insured. We are currently studying the desirability of exempting the health benefits program from these taxes and will issue a separate report to you on this matter.

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FRAUD AND ABUSE

Another area which appears to lack effective oversight and control concerns the vulnerability of the health benefits program to fraud and abuse. During the past several years, instances of fraud and abuse have been identified in at least six of the largest plans. In 1984, over one million dollars was embezzled by officials of one plan (American Postal Workers Union) and in 1982 about $35,000 was embezzled by an official of another plan (National League of Postmasters). Officials from both plans were subsequently prosecuted, found guilty, and the monies were returned to the program. OPM's plan audits which serve as the primary internal control to prevent fraud and abuse, identified two plans (American Federation of Government Employees and National Alliance of Federal Employees) which used commingled health benefit program and union funds to finance union operations during the 7-year period ending in 1985. The unions subsequently repaid the monies and OPM has issued regulations prohibiting the commingling of program funds. OPM's audits also identified that another plan (Mail Handlers) improperly charged the program about $1 million in 1984 for facilities rented to other parties. The pla settled the matter by repaying the funds along with civil penalties after the matter was referred to the Justice Department for prosecution.

We found a serious abuse of program funds by one plan (Aetna), which improperly charged the health benefits program over $7 million for federal income taxes it paid on plan profits for six years ending in 1987. Federal procurement regulations expressly prohibit the charging of federal income taxes to government contracts. OPM officials had not caught these improper charges when they reviewed the plan's accounting statements. Last December we reported[2] our findings to OPM's program administrator and recommended that the funds be recovered. OPM has since recovered the $7 million.

We also found that despite the potential for significant losses, OPM had not required plans to monitor claims to detect provider and enrollee fraud and abuse. Although OPM intends to insert a clause in its 1990 contracts requiring procedures for detecting fraud and abuse, the nature and extent of the monitoring will be the prerogative of the plans. Officials at several of the largest plans said their current practice for dealing with suspected fraudulent providers is to closely monitor future claims but referral for prosecution is usually not considered.

The Federal Employees Health Benefits Amendments Act of 1988 permits OPM to exclude from the program health care providers who are found guilty of criminal fraud or unethical practices, but

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[2]Federal Compensation: Recovery of Improper Health Benefits Charges Needed (GAO/GGD-89-27, Dec. 13, 1988).

OPM has not as yet developed regulations to implement this authority. Also, it has not set a date for issuing these regulations.

The Federal Managers' Financial Integrity Act (FIA) of 1982 requires executive agencies to establish and maintain systems of internal control. Internal control systems are to reasonably ensure that among other things, all assets are safeguarded against waste, loss, unauthorized use, and misappropriation. The act requires the heads of executive agencies to make annual evaluations of their internal controls and provide annual reports to the President and Congress on whether agency systems of internal control comply with the objectives set forth in the act.

Notwithstanding the reported instances of fraud and abuse, OPM officials responsible for the health program did not consider the program funds to be particularly vulnerable to loss. These officials were operating under the mistaken belief that FIA vulnerability assessment requirements did not extend to the activities of the health benefit plans. Also, the internal control coordinator, who prepared OPM's annual FIA reports to Congress covering insurance programs, said he was unaware that any fraud or abuse involving program funds had occurred. OPM lacks a systematic mechanism to inform him of such instances and he did not ask the program manager. Hence, OPM neither regarded the program to be highly vulnerable to fraud and abuse nor

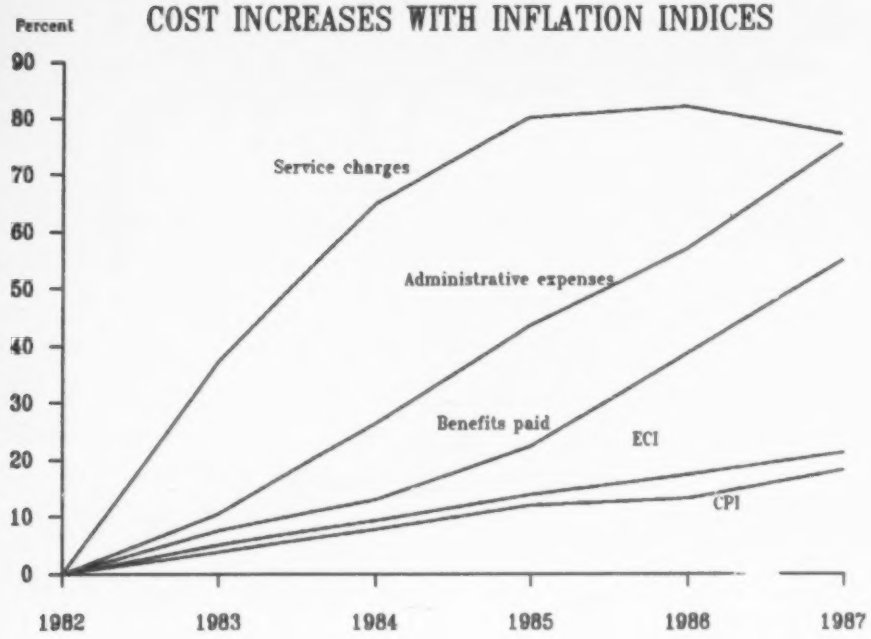
identified the program as having any material internal control weaknesses in its annual FIA reports.

More effective vulnerability assessments and oversight over the program could help OPM to identify weaknesses in its systems of internal control that have allowed instances of fraud and abuse to occur. In addition, controls to prevent fraud and abuse could be improved by expediting the implementation of regulations to exclude payments to providers found guilty of fraud or unethical practices. We plan more work to identify further actions OPM and the plans could take to prevent fraud and abuse.

In closing, Mr. Chairman, I would like to emphasize that effective cost containment incentives for and oversight and control over administrative expenses and the vulnerability of program funds to fraud and abuse should be of continuing concern to the program's administrator. This concludes my statement. I would be pleased to respond to questions.

ATTACHMENT ATTACHMENT

COMPARISON OF HEALTH BENEFITS PROGRAM COST INCREASES WITH INFLATION INDICES



ECI = Employment cost index

CPI = Consumer price index

GAO RESPONSE TO ADDITIONAL QUESTIONS SUBMITTED FOR THE RECORD

COMMITTEE ON POST OFFICE AND CIVIL SERVICE
SUBCOMMITTEE ON COMPENSATION AND EMPLOYEE BENEFITS
HOUSE OF REPRESENTATIVES

Question 1

Your chart shows that over the past five years administrative costs have escalated far beyond the medical and CPI increases. Is there any incentive for plans to overcharge for administrative expenses? Is there any incentive for plans to restrain their administrative costs?

GAO Response

The plans' administrative expenses are subject to audit by OPM. However, there are no penalties for overcharges detected through the audit process and interest is not assessed as long as a plan repays the amount requested by OPM's contract officer within 90 days. Together with the 3- to 10-year time lag between audits, the interest-free use of government funds could be an incentive for making improper charges. For example, Aetna, which we found had been improperly charging the program for federal income taxes since 1982, had not been audited in seven years. We estimate that Aetna could have earned over $1 million in interest on the $7 million overcharged by Aetna before refunding the overcharge to the program.

In our opinion, the plans have had little incentive to keep administrative costs down. They are fully reimbursed by the program for amounts actually spent on expenses allowed under the regulations as long as their total expenses do not exceed contractual expense ceilings. Generally, the ceilings have not functioned as a restraint. They were often set by OPM at levels far above the plans' actual costs which gave the plans considerable latitude in determining their own expense levels. OPM is now negotiating ceilings that will only permit expense increases above a base year in proportion to growth in enrollment and inflation. While this should help to control future cost increases, any administrative inefficiencies reflected in the base years' expenses would continue to be funded.

Question 2

The examples of fraud and abuse you list are generally 3 or 4 years old. Is there reason to believe that this sort of thing is still going on?

GAO Response

Although OPM has implemented new regulations which should help to prevent some of the examples cited in our testimony, we believe that program funds may still be vulnerable to fraud and abuse. Plans are now prohibited from commingling program funds with other resources as occurred in two of the cases cited. Also, under the letter-of-credit procedures recently implemented for disbursing funds, OPM rather than the plans will hold the program's special reserves. Nevertheless, OPM still lacks reasonable assurance that the plans' internal controls are adequate to protect program funds from abusive plan practices, including the two examples we cited involving obviously improper overcharges, as well as from false claims filed by providers and enrollees which result in benefit overpayments. Absent such assurance, we believe that the possibility for fraud and abuse still exists.

DISTRIBUTION OF PREMIUM TAX CHARGES
BY GOVERNMENT ENTITY

States	Amount
Alabama	$2,598,000
Alaska	465,000
Arizona	847,000
Arkansas	456,000
California	4,169,000
Colorado	633,000
Connecticut	479,000
Delaware	72,000
Florida	2,026,000
Georgia	1,756,000
Hawaii	99,000
Idaho	350,000
Illinois	410,000
Indiana	616,000
Iowa	453,000
Kansas	370,000
Kentucky	606,000
Louisiana	641,000
Maine	303,000
Maryland	1,579,000
Massachusetts	499,000
Michigan	550,000
Minnesota	297,000
Mississippi	1,149,000
Missouri	709,000
Montana	267,000
Nebraska	260,000
Nevada	399,000
New Hampshire	239,000
New Jersey	696,000
New Mexico	642,000
New York	757,000
North Carolina	970,000
North Dakota	61,000
Ohio	1,520,000
Oklahoma	1,562,000
Oregon	438,000
Pennsylvania	1,484,000
Rhode Island	87,000
South Carolina	1,116,000
South Dakota	271,000
Tennessee	1,506,000
Texas	2,180,000[a]
Utah	978,000
Vermont	98,000
Virginia	3,032,000
Washington	809,000
West Virginia	383,000
Wisconsin	252,000
Wyoming	132,000
Subtotal	$42,271,000
Other Recipients	
District of Columbia	734,000
Panama	$1,375,000
County and municipal governments	265,000
U.S. Territories	54,000
Subtotal	$2,428,000
Total	$44,699,000
Unspecified	$105,000
Grand total	$44,804,000[b]

[a]Taxes for 1987 were reduced to about $2.2 million by a special tax credit of about $2.3 million granted one plan.

[b]The grand total of $44.8 million shown above is about $700,000 more than the $44.1 million actually charged to the program in 1987, largely because two of the plans reported their distribution on a cash basis while the plans reported the amount actually charged to the program on an accrual basis.

Mr. ACKERMAN. Thank you very much.

Without objection, your entire testimony as presented to the committee will be placed in the record.

In your testimony you stated that approximately $44 million could be saved by exempting FEHBP plans from payment of premium taxes. In addition to the 50 States that we have, what are the "other Government entities" that you referred to?

Mr. UNGAR. Mr. Chairman, one is the Republic of Panama. I will have Mr. Eickmeyer give you some more details on that.

Mr. EICKMEYER. Mr. Chairman, we were analyzing the payments made in 1987. It included about $1.4 million that was paid to the Republic of Panama as premium taxes for the underwriter, Mutual of Omaha.

Since that time, in 1988, the Government has issued an Executive Order that barred payments of private sector firms to the Government of Panama. It allowed Treasury to issue exceptions to that Executive Order. In 1988, the Mutual of Omaha officials sought an exception to that Executive Order and were granted an exception and paid about $750,000 to Panama in 1988.

Mutual told us that they sought it because their officials in Panama were threatened with jailing for not paying the premium taxes.

Mr. ACKERMAN. You're telling me that in 1987, part of Federal employees' premiums went to the Government of Panama to the tune of $1.4 million, and last year three-quarters of a million dollars?

Mr. EICKMEYER. That's correct.

Mr. ACKERMAN. And we had to get an exemption. What we don't allow other people to do, the Government said we should do that?

Mr. EICKMEYER. That's correct.

Mr. ACKERMAN. Does that add anything to the drug coverage we're looking for? [Laughter.]

Mr. EICKMEYER. I can't answer that.

Mr. ACKERMAN. Why on earth would we be doing that?

Mr. UNGAR. Mr. Chairman, in this particular case the policy was not to do it, but apparently, from what we understand, Mutual of Omaha came to the Government and said we've got a real problem. Our people are threatened with jail. So it was under that type of situation that the Government went ahead and gave the exemption to make the payment.

Mr. ACKERMAN. I would presume that every American company doing business in Panama is under the same threat, and when that Executive order was issued, it was clearly understood that the Government of Panama would not be happy, and yet other American companies were expected to keep their feet to the fire in order to prevent—because of other national policies that we have—money flowing into that government.

Is there any reason why Federal employees' money, through Mutual of Omaha, was singled out to be given to the Panamanian Government?

Mr. UNGAR. Mr. Chairman, we really didn't look at that in depth in our review, so we're not really in a position to give you all the information. We could try to make some additional inquiries and find out what has happened with the policy and whether there are

any other exemptions. We just looked specifically at this particular program.

Mr. ACKERMAN. Whatever light you can shed on it would be greatly appreciated. Many of us on the full committee, coincidentally, sit on Foreign Affairs as well, an unusual number. I think this would bear looking into by that committee as well as this one. So any information you can provide will be greatly appreciated.

You state in your testimony that the Federal Managers Financial Integrity Act requires agencies to protect Federal funds from waste and abuse, as well as other unauthorized use. Yet OPM believes that the Act does not apply to FEHBP.

Who's right?

Mr. UNGAR. We are.

Mr. ACKERMAN. Okay. You can expand on that.

Mr. UNGAR. Mr. Chairman, the Federal Financial Manager's Integrity Act basically applies to Federal agencies and to Federal programs, activities and functions. As you know, a lot of Federal organizations do business through contractors or grantees. While the Act doesn't directly apply to them, the Act applies to the Federal managers of the program. For example, the Department of Energy does a lot of business with contractors. The Act doesn't apply to its contractors—in other words, the process by which coming up with an annual report to the Congress and the President doesn't filter down to the contractors of DOE, but it does require that the Department of Energy go through a review process and at the end of every year report to the President and to the Congress on the state of their internal controls. In the case of DOE, it has basically imposed the requirement by contract, at least it did, on its contractors.

If you look at OPM, it is responsible for this health benefits program. Therefore, it's managers are responsible for making sure that the program has adequate controls and that annually there is a report provided to the Congress on the state of those controls.

It has responsibility for reviewing the program, the function and activities that are carried out by its contractors—in this case, the carriers, such as Blue Cross and Aetna—making sure that they have adequate controls as well as OPM. Then, if there are problems, getting those corrected and including those in reports in terms of if there are material weaknesses.

In the case of this program, what OPM seems to be saying is that because the program operates by contractors, it is not subject to the Financial Integrity Act. That's just not the case. Again, the contractors aren't, but OPM is. We feel that it ought to take a look at the controls it has imposed, either through the contracts or through its audits, determine what the objectives of the controls are, determine whether or not they're effective, and if not, then to address those through additional studies or measures that would be corrective.

And so we basically disagree with OPM.

Mr. EICKMEYER. If I could expand that a bit, another thing that concerns us very much in that area, when we met with the officials responsible for implementing that Act in OPM, they told us they were unaware of any fraud and abuse in the health benefits program. We found that they had no mechanism to provide them the

information on the cases that had been identified, nor did they ask the program managers what cases of fraud and abuse are occurring in their program. We think it is important that OPM set up a mechanism to advise their top officials of the fraud and abuse in the program.

Mr. ACKERMAN. Thank you very much.

Don't the plans or OPM have internal audits designed to uncover or prevent abuses?

Mr. UNGAR. Mr. Chairman, we're still in the process of looking into this in more depth. Our understanding right now is that many of the plans do have internal audits which they can charge back to OPM through their administrative costs. But our understanding now is that generally they do not cover—that the audits that are undertaken by the plans do not generally cover administrative costs. They cover eligibility of the beneficiaries and the health benefits paid.

Mr. Eickmeyer, would you like to comment on that?

Mr. EICKMEYER. For example, we inquired of Aetna why their internal auditors had not disclosed that the plan had been improperly charging the Government for six straight years for Federal income taxes that were an unallowable cost. What we were told was that the internal auditors do not look at the administrative costs of the program and, as a result, would never have analyzed those costs for allowability.

Mr. ACKERMAN. Let me thank you, Mr. Ungar, and the panel. You have been very, very helpful to the committee.

Without objection, the record of today's hearing will be kept open for 30 days to allow all interested parties to submit comments regarding the CRS report and the testimony that we have received this morning and this afternoon.

Thank you very, very much.

[Whereupon, at 1:50 p.m., the subcommittee was adjourned.]

[The following statements were received for the record:]

Employee Benefits Division
151 Farmington Avenue - MB66
Hartford, CT 06156

Charles T. Bell
Vice President
(203) 636-6617

June 9, 1989

The Honorable Gary L. Ackerman
Chairman, Subcommittee on Compensation and
Employee Benefits
515 House Office Building, Annex I
Washington, DC 20515

Dear Chairman Ackerman:

In testimony recently delivered before your Subcommittee, the General Accounting Office made note of a federal income tax problem involving Ætna Life Insurance Company ("Ætna") and the FEHBP plan. The GAO referred to this issue as an abuse of program funds costing FEHBP a substantial sum. Because this statement seriously mischaracterizes the situation, I am writing to provide you with clarifying information. I request that you include this letter in the published proceedings of your Subcommittee's hearings of May 24, 1989.

The item at issue involves the appropriateness of charging FEHBP for federal taxes on Ætna's service charges during the period from 1982 to 1987. Prior to 1982, Ætna was taxed solely on investment income for its FEHBP activity as dictated by life insurance company tax laws. Thus, taxes did not enter into consideration of the annual service charge.

In 1982, and then again in 1985 (because of federal tax law changes) the tax status of Ætna changed. This required a change in our accounting under FEHBP, resulting in a charge to the plan for taxes incurred with respect to our service charge.

During the period in question (1982-1987) Ætna operated on the clear belief that taxes on its FEHBP service charge could be charged to the benefits plan. In correspondence to OPM, first in 1982 and then in 1985, we pointed out the impact of tax law changes on insurance companies. We specifically indicated how such changes related to a company such as Ætna participating in FEHBP. Our correspondence noted as well our intention to charge the plan for service fee taxes.

This belief was never questioned by OPM. Furthermore, in addition to notifying OPM of this practice, the tax charges on the service fee were clearly spelled out in our Annual Accounting Statement each year from 1982 onward.

We had no reason to believe there was any problem, since we openly and quite publicly followed this practice for several years. Until we received OPM's letter of November 23, 1988, we had every reason to believe our accounting methodology was proper.

When notified in November of 1988 that these expenses were not allowable charges, we reviewed the issue and determined that the regulations could be interpreted to preclude charges for federal income taxes on such service charges. Following our review, we immediately curtailed the practice and have credited $7.2 million back to the plan, effective in 1988.

This mistake was an unfortunate error on the part of both Ætna and OPM, but these charges were honest oversights stemming from our belief that they were proper. It would be unfair to both Ætna and OPM to suggest otherwise.

By including this letter in the proceedings of the hearing of May 24, 1989 on FEHBP, you will, in our judgment, provide the record with a more complete and accurate picture of this issue.

Sincerely,

Charles T. Bell

Charles T. Bell
Vice President

sdr

KAISER FOUNDATION HEALTH PLAN, INC.

COMMENTS ON THE

CONGRESSIONAL RESEARCH SERVICE REPORT

"THE FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM
- POSSIBLE STRATEGIES FOR REFORM"

Kaiser Foundation Health Plan, Inc. ("Health Plan") operates fourteen plans that participate in the Federal Employees Health Benefits Program, including the Northern California and Southern California Regions, which are two of the "Big Six" plans used to calculate the government contribution. Over 550,000 federal employees, annuitants and their dependents are enrolled in Health Plan. Health Plan has participated in the FEHBP since its inception.

Health Plan has reviewed the report prepared by the Congressional Research Service (CRS) entitled "The Federal Employees Health Benefits Program - Possible Strategies for Reform." This report thoroughly analyzes the existing program. The CRS should be commended for its fine, original and impartial evaluation of the FEHBP.

The report acknowledges that there are some substantial problems. Unlike other analyses of the FEHBP, it does not urge the implementation of questionable administrative practices or the

retention of elements of the program which have led to its primary problems on the false promise of cost savings. It forthrightly states that government costs can be limited only by cutting prepaid benefits, shifting costs to employees and annuitants, or imposing direct cost controls on physicians and hospitals. It notes, in this regard, that federal employees and annuitants already pay more for coverage than comparable persons in the private sector.

The major problem confronting the FEHBP relates to cost. The cost to the government is unpredictable and seemingly unstable, although the report points out that average annual cost increases during the past eight years are comparable to those experienced by private employers. The instability stems from the manner in which the government contribution is calculated. The instability is aggravated by the exceptionally high premiums needed to fund the two government-wide high option plans, since the "Big Six" formula, which is used as the basis for establishing the annual amount to be contributed on behalf of each enrollee, includes the two plans. The government-wide plans high option premiums are affected by the significant maldistribution of risk within these two plans. Essentially, the highest cost, highest risk group of employees and annuitants have a disproportionate effect on the determination of the government contribution. The report also notes that the cost of the two high option plans are disproportionately high in relation to the value of benefits provided. Thus, their enrollees pay far too much for the coverage they purchase.

The unstable nature of the government contribution and the concentration of the high risk, high cost individuals in the two government-wide plans are the primary reasons the FEHBP is experiencing difficulty. These are problems with remedies. Unlike other pronouncements on the terrible state and imminent demise of the FEHBP, the CRS Report recognizes that the problems are correctable.

The CRS identified three strategies for reforming the program, each of which would rectify the major difficulties. Strategy 1 involves simple reform of the existing structure. Strategy 2 establishes a more elaborate reform by reducing the number of fee-for-service carriers. Strategy 3 is a wholesale restructuring by having only one plan, with more limited HMO options. Each strategy proposed by CRS looks at benefit design, cost control measures, choice, premium shares, annuitants and financing. Health Plan offers the following observations about each of the components of this reform strategy.

BENEFIT DESIGN

The CRS Report concludes that a minimum benefit level is necessary to ameliorate the uneven distribution of risk that is one of the FEHBP's most extensive problems. The need to establish a minimum level of acceptable benefits is directed primarily at the fee-for-service plans. However, some minimum benefits may have to be added to the HMO benefit packages. OPM is now requiring all HMO plans participating in the FEHBP to provide the

benefits mandated by the HMO Act, whether or not federally qualified. (This policy has been implemented by OPM for 1990.)

The report also notes that many of the fee-for-service carriers benefits are difficult to determine, due to the fee schedules used by the carrier. In many cases, these schedules result in substantially less benefits than provided by the government-wide plans or the HMOs. Thus, CRS recommends, and Health Plan concurs, that there should be a minimum acceptable level of benefits.

COST CONTROL

Not surprisingly, the CRS Report indicates that OPM should more aggresively implement cost control objectives, although the strength of those objectives varies with the strategy selected. Health Plan agrees that cost control measures are necessary to more effectively manage the FEHBP.

While cost control measures should be implemented for all plans, any reform should recognize the need for flexibility to allow different types of plans to use alternate cost control measures. CRS concentrates primarily on the fee-for-service plans in its discussion of cost controls. The report recognizes that HMOs have incentives to control costs and that many of the processes used by HMOs are being implemented by other carriers. As long as fee-for-service reimbursement depends on the number of services rendered, cost control measures for indemnity carriers must differ from prepaid group practice plans and other HMOs. Any

mandated cost controls must take into account the differences between the types of carriers.

CHOICE

The FEHBP has been criticized for having too many choices of carriers. Too often, the complaints against choice have been directed at HMOs because almost 400 HMOs are participating carriers. The CRS Report notes that, at most, only 15 HMOs are available to any employee or annuitant. Over 20 fee-for-service plans are available to every federal employee or annuitant. It is important to note that the CRS believes that choice, by itself, has not been a major factor in contributing to the cost of the FEHBP. The report acknowledges that choice is what has isolated the risk pool of the two government-wide high option plans, as a result of the general availability of other "government-wide" plans offered by the employee organization fee-for-service plans.

Health Plan supports the CRS recommendation of an unlimited HMO option (Strategy 1 or Strategy 2), but believes that the limited, but significant, HMO presence in the third strategy also is acceptable. Federal employees and annuitants like other Americans want a broad choice of health benefit plans.

However, reform must deal with the issue of choice, to reduce the possibility of insidious risk selection. Risk, as the CRS Report makes clear, is inherent among a substantial range of fee-for-service plans. When the products are not differentiated, and when many of the employee organization plans are simply additional government-wide carriers, choice has gone beyond

reasonable limits. Enrollment in the employee organization plans should be limited to members of the employee organizations and the practice of allowing employee organizations to enroll persons who are not members of the employee organization as associate members should be discontinued.

Multiple options also add unnecessarily to choice. There seems to be little justification for retaining the high and "standard" option requirement for the government-wide plans, or for allowing employee organization plans or HMOs to offer two options.

PREMIUM SHARING AND ANNUITANTS

The purpose of any change should be to provide a stable, predictable base for determining the government contribution, to compensate plans fairly on the basis of the risks they assume and to pay a fair share of the premium on behalf of the enrollees.

Health Plan believes that the most significant steps toward reform can be made by redefining the government contribution formula and by taking into account that federal employees and annuitants comprise four distinct risk pools.

The four separate risk pools within the FEHBP are:

1. Active employees;
2. Annuitants under age 65;
3. Annuitants over age 65 without Medicare Parts A and B;
4. Annuitants over age 65 with Medicare Parts A and B.

Each of these risk pools has different cost profiles. Based on studies conducted by Health Plan (and corroborated by the CRS data, as well as the data in the TPF&C Report), the cost of Parts A and B Medicare beneficiaries is less than the average plan cost, while the cost for the annuitants (over and under age 65) without Medicare is higher than average, with the cost for annuitants over the age of 65 without Medicare being the highest. Without Medicare to pay for the cost of services, annuitants are extremely high risk, high cost people. (They are concentrated in the two government-wide plans, which obviously has affected the contribution calculation.) It is possible to develop rates for each of these risk pools which will more accurately reflect the cost of providing health care services to each pool.

1. Medicare Covered Annuitants

By separately rating annuitants over the age of 65 with Medicare Parts A and B, Congress can effectively implement the Medicare supplemental option. The supplemental premium would be substantially lower than the premium for standard coverage under the FEHBP. Even if the government paid 75% of the supplemental premium, as recommended by CRS, its costs would be less than under the current system. Out of pocket costs to the enrollees also would be substantially lower, since they would pay 25% of the smaller supplemental premium. (They would be expected to pay the Part B premium, as well.) The supplemental option should require that total benefits, that is, Medicare covered benefits and benefits provided under the supplemental plan, are no less than those which enrollees receive under the existing FEHBP plan, and

in all cases, copayments and deductibles should not be charged to persons covered under the supplemental plan.

By establishing a separate rate for a Medicare supplemental plan, and having such a benefit available to annuitants, it will be possible to integrate the Medicare risk program into the FEHBP. As the two programs are structured, there is no incentive for any person in the FEHBP to enroll in the risk program. The annuitant would have to pay the employee share of the contribution, the Part B premium and the supplemental plan's premium to enroll. Since annuitants enrolled in Medicare are overinsured (or overpay for their coverage), there is no reason for them to pay the risk premium in addition to the Part B premium. The lower cost of the restructured program would permit a more effective interface between the two programs and would enable the government to obtain the advantages of the risk program for its Medicare eligible retirees.

2. Actives

A separate rate for actives would lower the rate to the government and to the active employees, as the active pool is the lowest risk, lowest cost of the four risk groups. The rate would not be lower than the Medicare supplemental rate.

3. Annuitants Without Medicare

Separate rates should be established for annuitants without Medicare. It is possible to rate the non-Medicare covered annuitants as one (all annuitants without Medicare) or two categories (those under age 65 and those over age 65 without Medicare). Ultimately, when the last of the over 65 annuitants without Medicare no longer exists (federal employees became eligible for Medicare in 1982, and at some point in time, all federal retirees over age 65 will have or be entitled to Medicare coverage), the only persons within this category will be persons under the age of 65. Eventually there will be one risk pool, so it may be preferable to establish a single rate category for these two risk pools. Either a single rate or two separate rates will result in premiums in excess of the rate charged for comparable benefits under the existing program. While the size of this risk pool is substantial under the existing structure of the FEHBP (there are many annuitants not eligible for Medicare), it will decline significantly, so that eventually, only a small portion of the federal eligibles (those persons under age 65 who retire and do not have Medicare coverage) will be subject to this rating category. Thus, relative costs for the FEHBP should decline over time if this strategy is implemented.

4. Determining the Contribution

The government contribution would have to take into account each risk pool in order to protect the employee or annuitant from bearing a greatly increased share of the cost. The active and Medicare supplemental rates should decrease, as both risk pools

are below the average of the FEHBP, the former because active employees are lower risk and lower cost than retirees and the latter because the cost of providing services will be shared more equitably between the FEHBP and Medicare. Thus, the government can maintain its level of contribution, or increase it in the case of the Medicare plan to 75%. For the annuitants that do not have Medicare, the costs will rise, probably substantially for some plans, and it will be necessary to adjust the contribution upward to prevent these annuitants from being unfairly compromised in their retirement benefits. A similar formula could apply, in other words, a percentage of that specific risk pool's rates could be contributed. While this may seem to add cost to the FEHBP, the savings from having separate active and Medicare pools could offset any added contribution resulting from the annuitants without Medicare risk pool. This pool will be substantially smaller than the active and Medicare-covered annuitant pools, and the demographics of this pool will change, because the annuitants over age 65 without Medicare will diminish significantly in the next few years.

These changes should remedy a significant part of the risk selection problem, as each plan would receive appropriate payment for the risk it undertakes. If, as is true for the government-wide plans, they have a much higher proportion of non-Medicare covered annuitants, they will be paid a rate commensurate with the costs they expect to incur. The separate rate for active employees will make the basic benefit package more

attractive to actives, because their rates will not subsidize the much higher cost annuitants.

5. Adopt a Three-Step Rate Structure

Rate setting can be further refined by adopting a three-step rate structure, rather than the existing two-step rate structure. This would substantially reduce subsidization between differing risk pools, which the report notes to be a significant concern to employees and annuitants. By having a two person family pay rates for two persons, and a three or more person family pay for three or more dependents, there is less cross-subsidization of families with children by families without children.

SUMMARY

Health Plan believes that the CRS Report is the most thorough analysis of the FEHBP. The report should form the basis for any action taken to reform the FEHBP. We believe the strategies offered by the report, as modified by the proposals made by Health Plan in this document, offer a fair, reasonable solution to the primary problems of the FEHBP. Health Plan has a vital interest in a sound FEHBP and will work with this committee to develop modifications of this important program.

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